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TITLE: Effects of Bright Light Therapy on Sleep, Cognition, Brain Function, and Neurochemistry in Mild Traumatic Brain Injury

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14. ABSTRACT
The study has made substantial progress over the past year. The emerging data on cognition, emotion, and subjective sleep suggest that six weeks of morning Blue Light Therapy versus comparable Amber Light Placebo supports our initial hypotheses that the treatment would improve sleep and cognition. Emerging data from functional magnetic resonance imaging tasks also suggest that the Blue Light condition was effective in altering brain responses during two demanding attention and working memory tasks, whereas such changes were not evident in the Amber Light Placebo condition. Overall, these findings suggest that the Blue Light treatment improved hippocampal functioning during working memory and was associated with prefrontal cortex activation during an attention-based conflict monitoring task. The initial findings point toward some beneficial effects of the active treatment in reducing daytime sleepiness and sleep-related functional impairments, improving subjective sleep, showing clinically significant improvements in attention, and affecting functional brain responses. The current data set is still small and we are exploring avenues to increase sample size to obtain sufficient power to detect reliable effects.

15. SUBJECT TERMS
Bright Light, Mild Traumatic Brain Injury, functional Magnetic Resonance Imaging (fMRI) Diffusion Tensor Imaging (DTI)

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INTRODUCTION:

With the large number of military personnel who have reported or suspected head injuries as a part of their military service (Hoge et al., 2008), the outcome of the present study could have significant impact on the delivery of health care to returning military veterans. Other than cognitive-behavioral therapies and avoidance of re-injury, there are few alternatives to treat symptoms of mild traumatic brain injury (mTBI) or concussion. Alternative approaches to treatment, or adjunctive therapies that can be used to augment ongoing interventions are clearly needed. Growing evidence suggests that sleep problems are particularly common following mTBI and may even affect the course of recovery. Sleep is critical to neurogenesis, neural plasticity, and removal of neurotoxins. Consequently, sleep enhancement seems to be an ideal candidate for direct intervention among individuals recovering from concussion. If sleep can be improved, it is more likely that other aspects of recovery will be accelerated. In particular, we hypothesize that sleep improvement will lead to improved emotional and cognitive functioning and that this will also enhance the effectiveness of ongoing adjunctive treatments. Growing evidence suggests that the sleep-wake cycle is strongly regulated by exposure to light, particularly in the blue wavelengths. Regular light exposure in the morning suppresses melatonin production early in the day and can re-entrain the circadian rhythm of sleep and wake. Therefore, it is hypothesized that, compared to an placebo device, daily use of morning blue light therapy device to entrain the circadian sleep-wake cycle, will lead to improvement of sleep in a sample of individuals with a recent history of mild TBI/ concussion, thereby increasing the likelihood that they will recover more quickly, and build emotional and cognitive resilience. If effective, the proposed approach could be used in isolation or as an adjunct to ongoing therapy to reduce the impact of mild TBI/ concussion and injury-related subjective symptoms, thereby facilitating a more rapid recovery. Even if the proposed light therapy fails to prove effective at improving sleep or symptom profiles, the obtained cognitive and neuroimaging data, neurocognitive testing, and actigraphy data will prove invaluable in developing further insights into the relationship between mild TBI/ concussion, sleep, and brain function.

The study design involves three visits to McLean Hospital. On the first visit, participants undergo a thorough screening for mTBI and qualified participants are fitted with a wrist actigraph for 24-hour a day continuous monitoring of sleep/wake cycles. Following a week of baseline actigraphy, participants return to the lab for the second visit, which involves a comprehensive neuropsychological assessment, neuroimaging scans, and a modified multiple sleep latency test (MSLT). At the end of the visit, each participant is randomly assigned to either an active treatment condition (Blue Light) or a placebo condition (Amber Light). Participants are provided with a device fitted with either blue or amber light emitting diodes (LEDs), which will be used for 30 minutes each morning, within two hours of awakening, and no later than 11:00 am. Participants use the light devices for 6 weeks and then return for the third visit to the lab. During the third visit, participants undergo a follow-up assessment session that is essentially identical to the previous assessment, including neuropsychological tests, neuroimaging, and MSLT. This past year, participants have also been instructed to wear an actigraph for an additional 6-weeks after the follow-up assessment to determine the durability of treatment effects.

The project has now completed its third year and is currently in a no-cost extension to permit additional data collection and to permit comprehensive analysis of the data.

BODY:

Accomplishments According to Statement of Work (SOW)

The study is progressing as planned. Consistent with the Statement of Work for YEAR 3 the following tasks have been accomplished:

SOW 1. Data collection will be 100% completed by the third quarter of Year 3.

Accomplishments:

- As of 14 JAN 2014, 183 potential volunteers have been screened, with 54 fulfilling criteria for study participation. Thus, 129 potential subjects were disqualified at phone screen. Of the eligible volunteers, 45 were scheduled to come in for the first study visit, of whom 38 attended the first session and were consented for the study. As of 14 JAN 2014, 32 subjects completed all phases of the study protocol, with 1 active subject who will complete study procedures by 28 FEB 2014. We withdrew 2 subjects from the study due to insufficient compliance with the study procedures. Furthermore, we discontinued 2 additional subjects, one who shoed claustrophobia in MRI scanner and another with evidence of pre-injury psychopathology. In addition, 1 subject withdrew from the study, as advised by her legal counsel because of pending legal proceedings associated with the concussion.
- In order to increase statistical power and to permit sufficient time to conduct data analysis, we requested a no cost extension to continue study recruitment and data collection, which was granted on 1 NOV 2013. We therefore are continuing to recruit participants and collect data. Comprehensive analyses are now underway.

SOW 2. The PI will analyze data and prepare manuscripts for publication during the second half of Year 3.

Accomplishments:

- Preliminary functional neuroimaging data for all completed subjects have been preprocessed in SPM8. Functional MRI data have been corrected for motion, realigned, normalized, and spatially smoothed. All functional imaging data have been inspected for artifacts using the Artifact Detection Program (ART), and covariate regressor files have been created for scans showing excess variability in global signal intensity and motion. Diffusion Tensor Imaging (DTI) data are currently being preprocessed in FSL (i.e., eddy current correction, reconstruction of diffusion tensors, estimation of diffusion parameters, registration to anatomical image and standard space). Structural image data (i.e., anatomical scans) were segmented into gray matter, white matter and cerebrospinal fluid in SPM8. To allow for analysis of intervention-related changes in cortical thickness and cortical volume, sophisticated segmentation using FreeSurfer has been finished, and quality of these segmentations is currently evaluated.
- Self-report data have been scored, checked, and entered into statistical databases. To allow for crosschecking of entered data, we used a double-entry approach by which two independent research assistants entered the data that was then checked by a postdoctoral fellow. Computerized neuropsychological assessment data have been downloaded and entered into statistical databases as well. All data have been visually and graphically inspected to ensure that they were entered correctly.
- Multiple Sleep Latency Test data have been quality-checked and submitted to two experienced polysomnography technicians for scoring.

- Several abstracts have been prepared and submitted for presentation at professional conferences. Most have been accepted as oral presentations over the past year and several more are scheduled for presentation in the coming months (see below).

SOW 3. **The PI will prepare a final report describing the effectiveness of blue light therapy for improving sleep and cognitive functioning and reducing symptoms of mTBI, and the functional and tractographic correlates of these changes within the brain.**

Accomplishments:

- Given that the study has moved into a no cost extension, a final report will not be due until the end of the extension period. Please see below for preliminary findings.
- Preliminary findings from the study have been presented at the Society of Biological Psychiatry conference, San Francisco, CA, 16 – 18 MAY 2013 (oral presentation) and the APSS SLEEP 2013 conference, Baltimore, MD, 1 – 5 JUN 2013 (oral presentation).
- Preliminary findings will be presented at the TBI Workgroup Meeting at The Spaulding Rehabilitation Hospital Boston, Charlestown, MA, 14 FEB 2014 (oral presentation).
- Preliminary findings will be presented at the 10th World Congress in Brain Injury, San Francisco, CA, 19 – 22 MAR 2014 (oral presentation).

Preliminary Research Findings

Shapiro-Wilk tests were conducted in R to evaluate the normal distribution of all behavioral variables of interest by group. Most of the variables were found to be non-normally distributed. Therefore, a robust data analysis approach was implemented in R (package: WRS) in order to investigate associations between light exposure and behavior.

The current sample contains complete data from 30 participants (age: 20% trimmed mean M_t=20.6, standard error of the trimmed mean SE_t=0.37; 16 female, 14 male; time since most recent document recent injury in days: 20% trimmed mean M_t=198.7, standard error of the trimmed mean SE_t=19.87), 15 who received the active bright Blue Light Treatment (age: 20% trimmed mean M_t=20.4, standard error of the trimmed mean SE_t=0.39, range: 18-35; 9 female, 6 male; time since most recent injury in days: 20% trimmed mean M_t=211.9, standard error of the trimmed mean SE_t=34.87, range 54-538) and 15 who received the Amber Placebo Treatment (age: 20% trimmed mean M_t=20.9, standard error of the trimmed mean SE_t=0.89, range: 18-29; 7 female, 8 male; time since most recent injury in days: 20% trimmed mean M_t=192.1, standard error of the trimmed mean SE_t=25.84, range 83-459). Age and time since injury do not differ between group (p=.62 and p=.92 respectively).

Below, we present interim study results on subjects with study protocol adherence of greater than 75% (n=25). Protocol adherence was defined as the percentage of days participants completed the "on line" sleep diary on the day they were supposed to (i.e., not retrospectively). Overall, the six-week blue light intervention yielded clinically significant improvements in sleep, cognition, and emotion relative to the six-week amber light placebo intervention (see Tables 1 to 3 and Figures 1 to 2).

Sleep and daytime sleepiness

Interim analyses of two self-report measures (Pittsburgh Sleep Quality Index PSQI; Epworth Sleepiness Scale ESS) tentatively suggest six weeks of morning Blue Light to improve subject sleep and daytime sleepiness compared to Amber Light. While there was no main effect of group (p=.105, 1-

tailed), there was a main effect of assessment session (pre-versus post tx) (p=.0065, 1-tailed) and a trend towards an interaction between group and assessment session (p=.075, 1-tailed). Inspection of average ranks and relative effects (i.e., the typical ranks across the combinations of groups and combined outcome measures) suggests greater improvements in sleep quality and daytime sleepiness in the Blue Light than Amber Light group (see Table 1).

Table 1: Average ranks and relative effects for the effect of group and light on subjective sleep and sleepiness

	Pre-intervention	Post-intervention
	Average ranks	
Blue Light group	55.80	38.90
Amber Light group	58.60	53.80
	Relative effects[1]	
Blue Light group	0.53	0.37
Amber Light group	0.59	0.51

[1] A relative effect of 0.5 signifies that there is no difference for this factor (i.e., group or assessment). Lower relative effects suggest lower scores on the variables of interest.

Depressive symptoms

Interim analyses of two self-report measures (Patient Health Questionnaire PHQ; Beck Depression Inventory BDI) tentatively suggest six weeks of morning Blue Light to reduce severity of depressive symptoms compared to Amber Light. While there was no main effect of group (p=.255, 1-tailed), there was a main effect of assessment session (p=.001, 1-tailed) and a trend towards an interaction between group and assessment session (p=.05, 1-tailed). Inspection of average ranks and relative effects suggests greater reductions in depressive symptoms in the Blue Light than Amber Light group (see Table 2).

Table 2: Average ranks and relative effects for the effect of group and light on depressive symptoms

	Pre-intervention	Post-intervention
	Average ranks	
Blue Light group	57.50	37.96
Amber Light group	55.63	49.28
	Relative effects[1]	
Blue Light group	0.57	0.37
Amber Light group	0.55	0.49

[1] A relative effect of 0.5 signifies that there is no difference for this factor (i.e., group or assessment). Lower relative effects suggest lower scores on the variables of interest.

Cognitive performance: Attention

Interim analyses were conduced on the Psychomotor Vigilance Test (PVT) speed and lapses (i.e., number of trials with reaction time greater than 500ms). There was a significant main effect of time (p<.001), with average ranks and relative effects suggesting speed reductions in both Blue Light and Amber groups. However, there was no significant effect of light on speed (p=.24, 1-tailed) and interaction between light and assessment (p=.14, 1-tailed). There was a significant main effect of time on PVT lapses, with average ranks and relative suggesting that lapses increased for both groups. Furthermore, there was trend for a main effect of light on PVT lapses (p=.05, 1-tailed), with average ranks and relative effects suggesting that PVT lapses were higher in the Amber Group than Blue Light group (p<.001). There was a an interaction between light and assessment (p=.025, 1-tailed), with

average ranks and relative effects suggesting a steeper increase in lapses between the pre- and post-assessment in the Amber Light than the Blue Light group (Table 3). We interpret this as suggesting that participants were somewhat more bored during the second session overall, leading to slower response times on the PVT, but that those in the Amber Light group were significantly more adversely affected by attentional lapses and response slowing than those in the Blue Light group.

Table 3: Average ranks and relative effects for the effect of group and light on PVT as a measure of attention

	Pre-intervention	Post-intervention
	Average ranks	
PVT Speed		
Blue Light	85.59	73.29
Amber Light	80.68	65.25
	Relative effects[1]	
Blue Light	0.57	0.49
Amber Light	0.53	0.43
	Average ranks	
PVT Lapses		
Blue Light	64.95	68.40
Amber Light	71.93	90.60
	Relative effects[1]	
Blue Light	0.43	0.45
Amber Light	0.48	0.60

[1] A relative effect of 0.5 signifies that there is no difference for this factor (i.e., group or assessment). Lower relative effects suggest lower scores on the variables of interest.

Neuroimaging

Figure 1 shows functional brain activation during the MSIT task, a cognitively demanding interference task that subjects performed in the MRI scanner pre-and post-intervention. Specifically, the figure depicts the change in brain activation between pre- and post-assessment for the interference condition in 22 subjects who presented with study protocol adherence greater than 75%. In line with the literature, the data tentatively suggest greater recruitment of the left prefrontal cortex/inferior frontal operculum during this task following six weeks of Blue Light compared to Amber Light.

Figure 1: Blue Light was associated with greater brain activation in the left opercular cortex during a cognitively demanding interference task compared to Amber Light (p<.005, uncorrected)

Figure 2 shows functional brain activation during the N-Back task, a working memory task that subjects performed in the MRI scanner pre-and post-intervention. Specifically, the figure depicts the change in brain activation between pre- and post-assessment for the most difficult task condition in 22 subjects who presented with study protocol adherence greater than 75%. Consistent with the literature, the data tentatively suggest greater recruitment of the bilateral hippocampi during this task following six weeks of Blue Light compared to Amber Light.

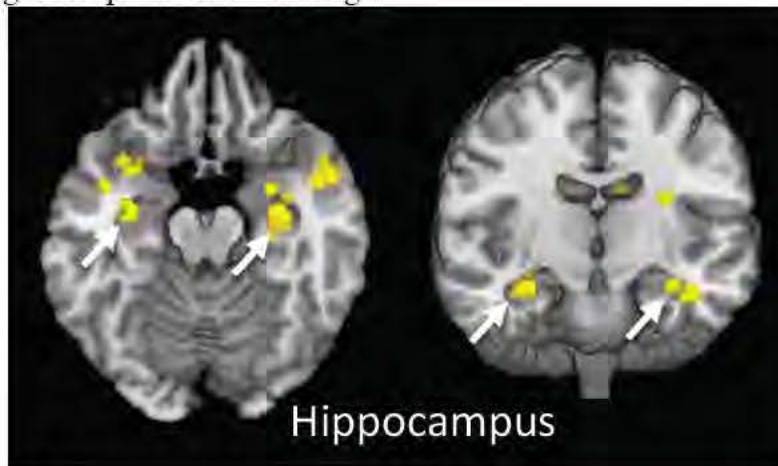Figure 2: Blue Light was associated with greater brain activation in bilateral hippocampus during a working memory task compared to Amber Light (p<.005, uncorrected)

Planned analyses include the incorporation of an objective measure of light exposure, as quantified by the data collected through the light sensor incorporated in the actiwatch. These data are currently being extracted and prepared for data analyses.

KEY RESEARCH ACCOMPLISHMENTS:

- Advertising and recruitment are ongoing.
- Data entry, quality checks, preprocessing and interim analyses are ongoing.
- 38 participants have been enrolled to date.
- 32 participants have completed the study.
- Preliminary results suggest that morning blue light therapy may improve sleep, cognition and emotion relative to a morning amber light placebo therapy of equal duration and intensity.

REPORTABLE OUTCOMES:

- Preliminary results were presented at national sleep and biological psychiatry conferences, yielding interest from health-related media outlets.
- Preliminary results will be presented at a national brain injury conference.

CONCLUSION:

The study has made substantial progress over the past year. The emerging data on cognition, emotion, and subjective sleep suggest that six weeks of morning Blue Light Therapy versus comparable Amber Light Placebo supports our initial hypotheses that the treatment would improve sleep and cognition. Emerging data from functional magnetic resonance imaging tasks also suggest that the Blue Light condition was effective in altering brain responses during two demanding attention and working memory tasks, whereas such changes were not evident in the Amber Light Placebo condition. Overall, these findings suggest that the Blue Light treatment improved hippocampal functioning during working memory and was associated with prefrontal cortex activation during an attention-based conflict monitoring task. The initial findings point toward some beneficial effects of the active treatment in reducing daytime sleepiness and sleep-related functional impairments, improving subjective sleep, showing clinically significant improvements in attention, and affecting functional brain responses. The current data set is still small and we are exploring avenues to increase sample size to obtain sufficient power to detect reliable effects.

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Hoge, C. W., McGurk, D., Thomas, J. L., Cox, A. L., Engel, C. C., & Castro, C. A. (2008). Mild traumatic brain injury in U.S. Soldiers returning from Iraq. *New England Journal of Medicine, 358*(5), 453-463.

APPENDICES:

Effects of Bright Light Therapy on Sleep, Cognition, Brain Function, and Neurochemistry in
Mild Traumatic Brain Injury

PI: William D. "Scott" Killgore, Ph.D.

Appendix: Study Measures/Assessments

Day 1 (Assessment Day)

1. Neurobehavioral Symptom Inventory (NSI)
2. Personality Assessment Inventory (PAI)
3. Screen Time Questionnaire (STQ)
4. MINI International Neuropsychiatric Interview (MINI)

Days 2 & 3 (Scan Days)

Pre-scan

5. Multi-Source Interference Task Practice
6. N-back practice
7. Stanford Sleepiness Scale (SSS)

Scan

8. Multi-Source Interference Task
9. N-back
10. Diffusion Tensor MRI
11. Resting State MRI

Post-scan

12. Repeatable Battery for the Assessment of Neuropsychological Status
13. Automated Neuropsychological Assessment Metrics (ANAM4) TBI Battery
14. Psychomotor Vigilance Test (PVT)
15. Multiple Sleep Latency Test (MSLT)
16. Invincibility Belief Index (IBI)
17. Go/No Go
18. Body Sway and Stability (BS&S)
19. Day of Scan Information Questionnaire
20. Morningness-Eveningness Questionnaire (MEQ)
21. Functional Outcome of Sleep Questionnaire (FOSQ)
22. Evaluation of Risk (EVAR)

■Computer Administration   ■Paper/Pen Questionnaires   ■Administered by Study Staff

23. Patient Health Questionnaire (PHQ)

24. Pittsburgh Sleep Quality Index (PSQI)

25. Rivermead Post-Concussion Symptoms Questionnaire (RPCSQ)

26. Beck Depression Inventory (BDI)

27. Balloon Analogue Risk Task (BART)

28. Spielberger State-Trait Anxiety Inventory – STATE

29. Spielberger State-Trait Anxiety Inventory – TRAIT

30. Tower of London (ToL)

6-Week Intervention Period

1. Sleep Diary

Appendix II: Symptom Checklist Included in VA's National Traumatic Brain Injury Evaluation and Treatment Protocol

NEUROBEHAVIORAL SYMPTOM INVENTORY

Please rate the following symptoms with regard to how much they have disturbed you *SINCE YOUR INJURY.*

0 = None- Rarely if ever present; not a problem at all

1 = Mild- Occasionally present, but it does not disrupt activities; I can usually continue what I'm doing; doesn't really concern me.

2 = Moderate- Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3 = Severe- Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel like I need help.

4 = Very Severe- Almost always present and I have been unable to perform at work, school or home due to this problem; I probably cannot function without help.

1. Feeling dizzy:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

2. Loss of balance:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

3. Poor coordination, clumsy:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

4. Headaches:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

5. Nausea:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

6. Vision problems, blurring, trouble seeing:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

7. Sensitivity to light

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

8. Hearing difficulty:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

9. Sensitivity to noise:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

10. Numbness or tingling on parts of my body:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

11. Change in taste and/or smell:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

12. Loss of appetite or increase appetite:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

13. Poor concentration, can't pay attention, easily distracted:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

14. Forgetfulness, can't remember things:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

15. Difficulty making decisions:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

16. Slowed thinking, difficulty getting organized, can't finish things:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

17. Fatigue, loss of energy, getting tired easily:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

18. Difficulty falling or staying asleep:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

19. Feeling anxious or tense:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

20. Feeling depressed or sad:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

21. Irritability, easily annoyed:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

22. Poor frustration tolerance, feeling easily overwhelmed by things:

0	1	2	3	4
NONE	MILD	MODERATE	SEVERE	VERY SEVERE

Personality Assessment Inventory (PAI)

Personality Assessment Inventory™ (PAI®)
Leslie C. Morey, PhD

Revised and updated materials help increase the accuracy of personality assessment.

Purpose:	22 nonoverlapping full scales provide a comprehensive assessment of adult psychopathology in ages 18 years and older
Age Range:	Adult Elder Adult
Admin:	Individual or group
Time:	50-60 minutes to administer; 15-20 minutes to score
Qualification:	C
Sample Reports:	N/A
Related Products:	PAI® Professional Report Service PAI® Software Portfolio Personality Assessment Inventory™-Adolescent

With its newly revised Professional Manual, Profile Form Adults-Revised, and Critical Items Form-Revised, the PAI® continues to raise the standard for the assessment of adult psychopathology. This objective inventory of adult personality assesses psychopathological syndromes and provides information relevant for clinical diagnosis, treatment planning, and screening for psychopathology. Since its introduction, the PAI has been heralded as one of the most important innovations in the field of clinical assessment.

PAI® Scales and Subscales

The 344 PAI items constitute 22 nonoverlapping scales covering the constructs most relevant to a broad-based assessment of mental disorders: 4 validity scales, 11 clinical scales, 5 treatment scales, and 2 interpersonal scales. To facilitate interpretation and to cover the full range of complex clinical constructs, 10 scales contain conceptually derived subscales.

The PAI Clinical scales were developed to provide information about critical diagnostic features of 11 important clinical constructs. These 11 scales may be divided into three broad classes of disorders: those within the neurotic spectrum, those within the psychotic spectrum, and those associated with behavior disorder or impulse control problems.

The Treatment scales were developed to provide indicators of potential complications in treatment that would not necessarily be apparent from diagnostic information. These five scales include two indicators of potential for harm to self or others, two measures of the respondent's environmental circumstances, and one indicator of the respondent's motivation for treatment.

The Interpersonal scales were developed to provide an assessment of the respondent's interpersonal style along two dimensions: a warmly affiliative versus a cold rejecting style, and a dominating/controlling versus a meekly submissive style. These axes provide a useful way of conceptualizing many different mental disorders: persons at the extremes of these dimensions may present with a variety of disorders. A number of studies provide evidence that diagnostic groups differ on these dimensions.

The PAI includes a Borderline Features scale and an Antisocial Features scale. Both of these scales specifically assess character pathology. The Borderline Features scale is the only PAI scale that has four subscales, reflecting the factorial complexity of the construct. The Antisocial Features scale includes a total of three facets: one assessing antisocial behaviors, and the other two assessing antisocial traits.

Subject Number: _____   Date:_____

In a typical week, we would like to know how much and when you are using your TV and Computer. Please place a C (computer) and/or T (television) in each hour time slot to indicate use.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
12AM							
1AM							
2AM							
3AM							
4AM							
5AM							
6AM							
7AM							
8AM							
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8PM							
9PM							
10PM							
11PM							

M.I.N.I.

MINI INTERNATIONAL NEUROPSYCHIATRIC INTERVIEW

English Version 6.0.0

DSM-IV

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DISCLAIMER

Our aim is to assist in the assessment and tracking of patients with greater efficiency and accuracy. Before action is taken on any data collected and processed by this program, it should be reviewed and interpreted by a licensed clinician.

This program is not designed or intended to be used in the place of a full medical and psychiatric evaluation by a qualified licensed physician – psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

	MODULES	TIME FRAME	MEETS CRITERIA	DSM-IV-TR	ICD-10	PRIMARY DIAGNOSIS
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks)	☐	296.20-296.26 Single	F32.x	☐
		Past	☐	296.20-296.26 Single	F32.x	☐
		Recurrent	☐	296.30-296.36 Recurrent	F33.x	☐
B	SUICIDALITY	Current (Past Month)	☐			
		☐ Low ☐ Moderate ☐ High				
C	MANIC EPISODE	Current	☐	296.00-296.06	F30.x-F31.9	☐
		Past	☐			
	HYPOMANIC EPISODE	Current	☐	296.80-296.89	F31.8-F31.9/F34.0	☐
		Past	☐			
	BIPOLAR I DISORDER	Current	☐	296.0x-296.6x	F30.x-F31.9	☐
		Past	☐	296.0x-296.6x	F30.x-F31.9	☐
	BIPOLAR II DISORDER	Current	☐	296.89	F31.8	☐
		Past	☐	296.89	F31.8	☐
	BIPOLAR DISORDER NOS	Current	☐	296.80	F31.9	☐
		Past	☐	296.80	F31.9	☐
D	PANIC DISORDER	Current (Past Month)	☐	300.01/300.21	F40.01-F41.0	☐
		Lifetime	☐			
E	AGORAPHOBIA	Current	☐	300.22	F40.00	☐
F	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)				
		Generalized	☐	300.23	F40.1	☐
		Non-Generalized	☐	300.23	F40.1	☐
G	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)	☐	300.3	F42.8	☐
H	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)	☐	309.81	F43.1	☐
I	ALCOHOL DEPENDENCE	Past 12 Months	☐	303.9	F10.2x	☐
	ALCOHOL ABUSE	Past 12 Months	☐	305.00	F10.1	☐
J	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1	☐
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months	☐	304.00-.90/305.20-.90	F11.1-F19.1	☐
K	PSYCHOTIC DISORDERS	Lifetime	☐	295.10-295.90/297.1/	F20.xx-F29	☐
		Current	☐	297.3/293.81/293.82/		
				293.89/298.8/298.9		
	MOOD DISORDER WITH	Lifetime	☐	296.24/296.34/296.44	F32.3/F33.3/	☐
	PSYCHOTIC FEATURES	Current	☐	296.24/296.34/296.44	F30.2/F31.2/F31.5	
					F31.8/F31.9/F39	☐
L	ANOREXIA NERVOSA	Current (Past 3 Months)	☐	307.1	F50.0	☐
M	BULIMIA NERVOSA	Current (Past 3 Months)	☐	307.51	F50.2	☐
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current	☐	307.1	F50.0	☐
N	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)	☐	300.02	F41.1	☐
O	MEDICAL, ORGANIC, DRUG CAUSE RULED OUT		☐ No ☐ Yes ☐ Uncertain			
P	ANTISOCIAL PERSONALITY DISORDER	Lifetime	☐	301.7	F60.2	☐

IDENTIFY THE PRIMARY DIAGNOSIS BY CHECKING THE APPROPRIATE CHECK BOX.
(Which problem troubles you the most or dominates the others or came first in the natural history?)

The translation from DSM-IV-TR to ICD-10 coding is not always exact. For more information on this topic see Schulte-Markwort. Crosswalks ICD-10/DSM-IV-TR. Hogrefe & Huber Publishers 2006.

GENERAL INSTRUCTIONS

The M.I.N.I. was designed as a brief structured interview for the major Axis I psychiatric disorders in DSM-IV and ICD-10. Validation and reliability studies have been done comparing the M.I.N.I. to the SCID-P for DSM-III-R and the CIDI (a structured interview developed by the World Health Organization). The results of these studies show that the M.I.N.I. has similar reliability and validity properties, but can be administered in a much shorter period of time (mean 18.7 ± 11.6 minutes, median 15 minutes) than the above referenced instruments. It can be used by clinicians, after a brief training session. Lay interviewers require more extensive training.

INTERVIEW:

> In order to keep the interview as brief as possible, inform the patient that you will conduct a clinical interview that is more structured than usual, with very precise questions about psychological problems which require a yes or no answer.

GENERAL FORMAT:

> The M.I.N.I. is divided into **modules** identified by letters, each corresponding to a diagnostic category.
> •At the beginning of each diagnostic module (except for psychotic disorders module), screening question(s) corresponding to the main criteria of the disorder are presented in a **gray box**.
> •At the end of each module, diagnostic box(es) permit the clinician to indicate whether diagnostic criteria are met.

CONVENTIONS:

> *Sentences written in* « normal font » should be read exactly as written to the patient in order to standardize the assessment of diagnostic criteria.

> *Sentences written in* « CAPITALS » should not be read to the patient. They are instructions for the interviewer to assist in the scoring of the diagnostic algorithms.

> *Sentences written in* « **bold** » indicate the time frame being investigated. The interviewer should read them as often as necessary. Only symptoms occurring during the time frame indicated should be considered in scoring the responses.

> *Answers with an arrow above them* (➡) indicate that one of the criteria necessary for the diagnosis(es) is not met. In this case, the interviewer should go to the end of the module, circle « **NO** » in all the diagnostic boxes and move to the next module.

> When terms are separated by a *slash (/)* the interviewer should read only those symptoms known to be present in the patient (for example, question G6).

> *Phrases in (parentheses)* are clinical examples of the symptom. These may be read to the patient to clarify the question.

RATING INSTRUCTIONS:

> All questions must be rated. The rating is done at the right of each question by circling either Yes or No. Clinical judgment by the rater should be used in coding the responses. Interviewers need to be sensitive to the diversity of cultural beliefs in their administration of questions and rating of responses. The rater should ask for examples when necessary, to ensure accurate coding. The patient should be encouraged to ask for clarification on any question that is not absolutely clear.
> The clinician should be sure that each dimension of the question is taken into account by the patient (for example, time frame, frequency, severity, and/or alternatives).
> Symptoms better accounted for by an organic cause or by the use of alcohol or drugs should not be coded positive in the M.I.N.I. The M.I.N.I. Plus has questions that investigate these issues.

A. MAJOR DEPRESSIVE EPISODE

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

A1	a	Were you <u>ever</u> depressed or down, most of the day, nearly every day, for two weeks?	NO	YES
		IF NO, CODE NO TO **A1b**: IF **YES** ASK:		
	b	<u>For the past two weeks,</u> were you depressed or down, most of the day, nearly every day?	NO	YES
A2	a	Were you <u>ever</u> much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for two weeks?	NO	YES
		IF NO, CODE NO TO **A2b**: IF **YES** ASK:		
	b	In the <u>past two weeks</u>, were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the time?	NO	YES
		IS **A1a** OR **A2a** CODED **YES**? ➡	NO	YES

A3   IF **A1b** OR **A2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
IF **A1b** AND **A2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

Over that two week period, when you felt depressed or uninterested:

		Past 2 Weeks		Past Episode	
a	Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e., by ±5% of body weight or ±8 lbs. or ±3.5 kgs., for a 160 lb./70 kg. person in a month)? IF **YES** TO EITHER, CODE **YES**.	NO	YES	NO	YES
b	Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES	NO	YES
c	Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?	NO	YES	NO	YES
d	Did you feel tired or without energy almost every day?	NO	YES	NO	YES
e	Did you feel worthless or guilty almost every day?	NO	YES	NO	YES

IF **YES**, ASK FOR EXAMPLES.
THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ❑ No ❑ Yes
Past Episode   ❑ No ❑ Yes

		Past 2 Weeks		Past Episode	
f	Did you have difficulty concentrating or making decisions almost every day?	NO	YES	NO	YES
g	Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead? Did you attempt suicide or plan a suicide? IF **YES** TO EITHER, CODE **YES**.	NO	YES	NO	YES
A4	Did these symptoms cause significant problems at home, at work, socially, at school or in some other important way?	NO	YES	NO	YES
A5	In between 2 episodes of depression, did you ever have an interval of at least 2 months, without any significant depression or any significant loss of interest?			NO	YES

ARE **5** OR MORE ANSWERS (**A1-A3**) CODED **YES** AND IS **A4** CODED YES
FOR THAT TIME FRAME?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

IF **A5** IS CODED **YES,** CODE **YES** FOR RECURRENT.

NO	YES
MAJOR DEPRESSIVE EPISODE	
CURRENT	☐
PAST	☐
RECURRENT	☐

A6   a   How many episodes of depression did you have in your lifetime?   _____

Between each episode there must be at least 2 months without any significant depression.

B. SUICIDALITY

In the past month did you:

B1	Suffer any accident? IF NO TO B1, SKIP TO B2; IF YES, ASK B1a:	NO	YES	0
B1a	Plan or intend to hurt yourself in that accident either actively or passively (e.g. not avoiding a risk)? IF NO TO B1a, SKIP TO B2: IF YES, ASK B1b:	NO	YES	0
B1b	Intend to die as a result of this accident?	NO	YES	0
B2	Feel hopeless?	NO	YES	1
B3	Think that you would be better off dead or wish you were dead?	NO	YES	1
B4	Want to harm yourself or to hurt or to injure yourself or have mental images of harming yourself?	NO	YES	2
B5	Think about suicide? IF NO TO B5, SKIP TO B7. OTHERWISE ASK:	NO	YES	6

Frequency   Intensity

Occasionally	☐	Mild	☐
Often	☐	Moderate	☐
Very often	☐	Severe	☐

Can you state that you will not act on these impulses during this treatment program?	NO	YES	
B6	Feel unable to control these impulses?	NO	YES	8
B7	Have a suicide plan?	NO	YES	8
B8	Take any active steps to prepare to injure yourself or to prepare for a suicide attempt in which you expected or intended to die?	NO	YES	9
B9	Deliberately injure yourself without intending to kill yourself?	NO	YES	4
B10	Attempt suicide? IF NO SKIP TO B11: Hope to be rescued / survive ☐ Expected / intended to die ☐	NO	YES	9

In your lifetime:

B11	Did you ever make a suicide attempt?	NO	YES	4

IS AT LEAST **1** OF THE ABOVE (EXCEPT B1) CODED **YES**?

IF YES, ADD THE TOTAL POINTS FOR THE ANSWERS (B1-B11)
CHECKED 'YES' AND SPECIFY THE SUICIDALITY SCORE AS
INDICATED IN THE DIAGNOSTIC BOX:

MAKE ANY ADDITIONAL COMMENTS ABOUT YOUR ASSESSMENT
OF THIS PATIENT'S CURRENT AND NEAR FUTURE SUICIDALITY IN
THE SPACE BELOW:

NO	YES

SUICIDALITY
CURRENT

1-8 points	Low	❏
9-16 points	Moderate	❏
$\geq$ 17 points	High	❏

C. MANIC AND HYPOMANIC EPISODES

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE **NO** IN MANIC AND HYPOMANIC DIAGNOSTIC BOXES, AND MOVE TO NEXT MODULE)

Do you have any family history of manic depressive illness or bipolar disorder,
or any family member who had mood swings treated with a medication like lithium,   NO   YES
sodium valproate (Depakote) or lamotrigine (Lamictal)?
THIS QUESTION IS NOT A CRITERION FOR BIPOLAR DISORDER, BUT IS ASKED TO INCREASE
THE CLINICIAN'S VIGILANCE ABOUT THE RISK FOR BIPOLAR DISORDER .
IF YES, PLEASE SPECIFY WHO:_____

C1 a Have you **ever** had a period of time when you were feeling 'up' or 'high' or 'hyper'   NO   YES
or so full of energy or full of yourself that you got into trouble, - or that
other people thought you were not your usual self? (Do not consider
times when you were intoxicated on drugs or alcohol.)

IF PATIENT IS PUZZLED OR UNCLEAR ABOUT WHAT YOU MEAN
BY 'UP' OR 'HIGH' OR 'HYPER', CLARIFY AS FOLLOWS: By 'up' or 'high' or 'hyper'
I mean: having elated mood; increased energy; needing less sleep; having rapid
thoughts; being full of ideas; having an increase in productivity, motivation,
creativity, or impulsive behavior; phoning or working excessively or spending more money.

IF NO, CODE NO TO **C1b**: IF **YES** ASK:

   b Are you currently feeling 'up' or 'high' or 'hyper' or full of energy?   NO   YES

C2 a Have you **ever** been persistently irritable, for several days, so that you   NO   YES
had arguments or verbal or physical fights, or shouted at people outside
your family? Have you or others noticed that you have been more irritable
or over reacted, compared to other people, even in situations that you felt
were justified?

IF NO, CODE NO TO **C2b**: IF **YES** ASK:

   b Are you currently feeling persistently irritable?   NO   YES
                                                             ➡
IS **C1a** OR **C2a** CODED **YES**?   NO   YES

C3   IF **C1b** OR **C2b** = **YES**: EXPLORE THE **CURRENT** AND THE MOST SYMPTOMATIC **PAST** EPISODE, OTHERWISE
       IF **C1b** AND **C2b** = **NO**: EXPLORE ONLY THE MOST SYMPTOMATIC **PAST** EPISODE

During the times when you felt high, full of energy, or irritable did you:

	Current Episode		Past Episode	
a Feel that you could do things others couldn't do, or that you were an especially important person? IF **YES**, ASK FOR EXAMPLES**.** THE EXAMPLES ARE CONSISTENT WITH A DELUSIONAL IDEA. Current Episode ☐ No ☐ Yes / Past Episode ☐ No ☐ Yes	NO	YES	NO	YES
b Need less sleep (for example, feel rested after only a few hours sleep)?	NO	YES	NO	YES
c Talk too much without stopping, or so fast that people had difficulty understanding?	NO	YES	NO	YES
d Have racing thoughts?	NO	YES	NO	YES

		Current Episode		Past Episode	
e	Become easily distracted so that any little interruption could distract you?	NO	YES	NO	YES
f	Have a significant increase in your activity or drive, at work, at school, socially or sexually or did you become physically or mentally restless?	NO	YES	NO	YES
g	Want so much to engage in pleasurable activities that you ignored the risks or consequences (for example, spending sprees, reckless driving, or sexual indiscretions)?	NO	YES	NO	YES

C3 SUMMARY: WHEN RATING CURRENT EPISODE: NO   YES   NO   YES

         IF C1b IS NO, ARE 4 OR MORE C3 ANSWERS CODED YES?
         IF C1b IS YES, ARE 3 OR MORE C3 ANSWERS CODED YES?

     WHEN RATING PAST EPISODE:
         IF C1a IS NO, ARE 4 OR MORE C3 ANSWERS CODED YES?
         IF C1a IS YES, ARE 3 OR MORE C3 ANSWERS CODED YES?

     CODE YES ONLY IF THE ABOVE 3 OR 4 SYMPTOMS OCCURRED DURING THE SAME TIME PERIOD.

     RULE: ELATION/EXPANSIVENESS REQUIRES ONLY THREE C3 SYMPTOMS, WHILE IRRITABLE MOOD ALONE REQUIRES 4 OF THE C3 SYMPTOMS.

C4	What is the longest time these symptoms lasted?		
	a) 3 days or less	❐	❐
	b) 4 to 6 days	❐	❐
	c) 7 days or more	❐	❐

C5	Were you hospitalized for these problems?	NO	YES	NO	YES

     IF YES, STOP HERE AND CIRCLE YES IN MANIC EPISODE FOR THAT TIME FRAME.

C6	Did these symptoms cause significant problems at home, at work, socially in your relationships with others, at school or in some other important way?	NO	YES	NO	YES

ARE **C3** SUMMARY AND **C5** AND **C6** CODED **YES** AND EITHER **C4a or b or c** CODED **YES**?

        OR

ARE **C3** SUMMARY AND **C4c** AND **C6** CODED **YES** AND IS **C5** CODED **NO**?

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO	**YES**
MANIC EPISODE	
CURRENT	❐
PAST	❐

ARE **C3** SUMMARY **AND C5** AND **C6** CODED **NO** AND EITHER **C4b** OR **C4C** CODED **YES**?

        OR

ARE **C3** SUMMARY AND **C4b** AND **C6** CODED **YES** AND IS **C5** CODED **NO?**

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

NO	**YES**
HYPOMANIC EPISODE	
CURRENT	❐
PAST	❐

ARE **C3** SUMMARY AND **C4a** CODED **YES** AND IS **C5** CODED **NO**?   **NO**   **YES**

HYPOMANIC SYMPTOMS

SPECIFY IF THE EPISODE IS CURRENT AND / OR PAST.

CURRENT   ☐
PAST   ☐

C7   a) IF MANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
        Did you have 2 or more manic episodes (**C4c**) in your lifetime (including the current episode if present)?   NO   YES

        b) IF HYPOMANIC EPISODE IS POSITIVE FOR EITHER CURRENT OR PAST ASK:
        Did you have 2 or more hypomanic EPISODES (**C4b**) in your lifetime (including the current episode)?   NO   YES

        c) IF PAST "HYPOMANIC SYMPTOMS" IS CODED POSITIVE ASK:
        Did you have 2 or more episodes of hypomanic SYMPTOMS (**C4a**) in your lifetime
        (including the current episode if present)?   NO   YES

D. PANIC DISORDER

(➡ MEANS : CIRCLE NO IN D5, D6 AND D7 AND SKIP TO E1)

D1	a	Have you, on more than one occasion, had spells or attacks when you **suddenly** felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?	➡ NO	YES
	b	Did the spells surge to a peak within 10 minutes of starting?	➡ NO	YES

D2		At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	➡ NO	YES
D3		Have you ever had one such attack followed by a month or more of persistent concern about having another attack, or worries about the consequences of the attack - or did you make a significant change in your behavior because of the attacks (e.g., shopping only with a companion, not wanting to leave your house, visiting the emergency room repeatedly, or seeing your doctor more frequently because of the symptoms)?	NO	YES
D4		**During the worst attack that you can remember:**		
	a	Did you have skipping, racing or pounding of your heart?	NO	YES
	b	Did you have sweating or clammy hands?	NO	YES
	c	Were you trembling or shaking?	NO	YES
	d	Did you have shortness of breath or difficulty breathing?	NO	YES
	e	Did you have a choking sensation or a lump in your throat?	NO	YES
	f	Did you have chest pain, pressure or discomfort?	NO	YES
	g	Did you have nausea, stomach problems or sudden diarrhea?	NO	YES
	h	Did you feel dizzy, unsteady, lightheaded or faint?	NO	YES
	i	Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?	NO	YES
	j	Did you fear that you were losing control or going crazy?	NO	YES
	k	Did you fear that you were dying?	NO	YES
	l	Did you have tingling or numbness in parts of your body?	NO	YES
	m	Did you have hot flushes or chills?	NO	YES
D5		ARE BOTH **D3,** AND **4** OR MORE **D4** ANSWERS, CODED **YES**? IF YES TO D5, SKIP TO D7.	NO	YES *PANIC DISORDER LIFETIME*
D6		IF **D5** = **NO,** ARE ANY D4 ANSWERS CODED **YES**? THEN SKIP TO **E1.**	NO	YES *LIMITED SYMPTOM ATTACKS LIFETIME*

D7   In the past month, did you have such attacks repeatedly (2 or more), and did you have   NO   YES
      persistent concern about having another attack, or worry about the consequences   *PANIC DISORDER*
      of the attacks, or did you change your behavior in any way because of the attacks?   *CURRENT*

E. AGORAPHOBIA

E1   Do you feel anxious or uneasy in places or situations where help might not be available
      or escape might be difficult, like being in a crowd, standing in a line (queue), when you
      are alone away from home or alone at home, or when crossing a bridge, or traveling
      in a bus, train or car or where you might have a panic attack or the panic-like   NO   YES
      symptoms we just spoke about?

IF **E1** = **NO**, CIRCLE **NO** IN **E2**.

E2   Do you fear these situations so much that you avoid them, or suffer   NO   YES
      through them, or need a companion to face them?   *AGORAPHOBIA*
                                                                                                             CURRENT

IS **E2** (CURRENT AGORAPHOBIA) CODED **YES**

  and

IS **D7** (CURRENT PANIC DISORDER) CODED **YES**?

NO	**YES**
PANIC DISORDER *with Agoraphobia* *CURRENT*	

IS **E2** (CURRENT AGORAPHOBIA) CODED **NO**

  and

IS **D7** (CURRENT PANIC DISORDER) CODED **YES**?

NO	**YES**
PANIC DISORDER *without Agoraphobia* *CURRENT*	

IS **E2** (CURRENT AGORAPHOBIA) CODED **YES**

  and

IS **D5** (PANIC DISORDER LIFETIME) CODED **NO**?

NO	**YES**
AGORAPHOBIA, CURRENT *without history of* *Panic Disorder*	

F. SOCIAL PHOBIA (Social Anxiety Disorder)

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO AND MOVE TO THE NEXT MODULE)

F1	In the past month, did you have persistent fear and significant anxiety at being watched, being the focus of attention, or of being humiliated or embarrassed? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.	➡ NO	YES

F2	Is this social fear excessive or unreasonable and does it almost always make you anxious?	➡ NO	YES
F3	Do you fear these social situations so much that you avoid them or suffer through them most of the time?	➡ NO	YES

F4 Do these social fears disrupt your normal work, school or social functioning or cause you significant distress?

SUBTYPES

Do you fear and avoid 4 or more social situations?

If YES   Generalized social phobia (social anxiety disorder)

If NO   Non-generalized social phobia (social anxiety disorder)

EXAMPLES OF SUCH SOCIAL SITUATIONS TYPICALLY INCLUDE
- INITIATING OR MAINTAINING A CONVERSATION,
- PARTICIPATING IN SMALL GROUPS,
- DATING,
- SPEAKING TO AUTHORITY FIGURES,
- ATTENDING PARTIES,
- PUBLIC SPEAKING,
- EATING IN FRONT OF OTHERS,
- URINATING IN A PUBLIC WASHROOM, ETC.

NOTE TO INTERVIEWER: PLEASE ASSESS WHETHER THE SUBJECT'S FEARS ARE RESTRICTED TO NON-GENERALIZED ("ONLY 1 OR SEVERAL") SOCIAL SITUATIONS OR EXTEND TO GENERALIZED ("MOST") SOCIAL SITUATIONS. "MOST" SOCIAL SITUATIONS IS USUALLY OPERATIONALIZED TO MEAN 4 OR MORE SOCIAL SITUATIONS, ALTHOUGH THE DSM-IV DOES NOT EXPLICITLY STATE THIS.

NO   YES

SOCIAL PHOBIA
(Social Anxiety Disorder)
CURRENT

GENERALIZED   ☐

NON-GENERALIZED   ☐

G. OBSESSIVE-COMPULSIVE DISORDER

(➡ MEANS: GO TO THE DIAGNOSTIC BOX, CIRCLE **NO** AND MOVE TO THE NEXT MODULE)

G1	In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? - (For example, the idea that you were dirty, contaminated or had germs, **or** fear of contaminating others, **or** fear of harming someone even though it disturbs or distresses you, or fear you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) (DO NOT INCLUDE SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS. DO NOT INCLUDE OBSESSIONS DIRECTLY RELATED TO EATING DISORDERS, SEXUAL DEVIATIONS, PATHOLOGICAL GAMBLING, OR ALCOHOL OR DRUG ABUSE BECAUSE THE PATIENT MAY DERIVE PLEASURE FROM THE ACTIVITY AND MAY WANT TO RESIST IT ONLY BECAUSE OF ITS NEGATIVE CONSEQUENCES.)	NO ↓ SKIP TO **G4**	YES

G2	Did they keep coming back into your mind even when you tried to ignore or get rid of them?	NO ↓ SKIP TO **G4**	YES
G3	Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?	NO	YES `obsessions`

G4	In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals?	NO	YES `compulsions`

	IS **G3** OR **G4** CODED **YES**?	➡ NO	YES
G5	At any point, did you recognize that either these obsessive thoughts or these compulsive behaviors were excessive or unreasonable?	➡ NO	YES

G6 In the past month, did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, your work or school, your usual social activities, or relationships, or did they take more than one hour a day?	**NO** **YES** *O.C.D.* *CURRENT*

H. POSTTRAUMATIC STRESS DISORDER

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

H1	Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?	➡ NO	YES
	EXAMPLES OF TRAUMATIC EVENTS INCLUDE: SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, WAR, OR NATURAL DISASTER, WITNESSING THE VIOLENT OR SUDDEN DEATH OF SOMEONE CLOSE TO YOU, OR A LIFE THREATENING ILLNESS.		
H2	Did you respond with intense fear, helplessness or horror?	➡ NO	YES
H3	During the past month, have you re-experienced the event in a distressing way (such as in dreams, intense recollections, flashbacks or physical reactions) or did you have intense distress when you were reminded about the event or exposed to a similar event?	➡ NO	YES

H4 **In the past month:**

a	Have you avoided thinking about or talking about the event ?	NO	YES
b	Have you avoided activities, places or people that remind you of the event?	NO	YES
c	Have you had trouble recalling some important part of what happened?	NO	YES
d	Have you become much less interested in hobbies or social activities?	NO	YES
e	Have you felt detached or estranged from others?	NO	YES
f	Have you noticed that your feelings are numbed?	NO	YES
g	Have you felt that your life will be shortened or that you will die sooner than other people?	NO	YES
	ARE **3** OR MORE **H4** ANSWERS CODED **YES**?	➡ NO	YES

H5 **In the past month:**

a	Have you had difficulty sleeping?	NO	YES
b	Were you especially irritable or did you have outbursts of anger?	NO	YES
c	Have you had difficulty concentrating?	NO	YES
d	Were you nervous or constantly on your guard?	NO	YES
e	Were you easily startled?	NO	YES
	ARE **2** OR MORE **H5** ANSWERS CODED **YES**?	➡ NO	YES

NO	YES
POSTTRAUMATIC STRESS DISORDER CURRENT	

H6 During the past month, have these problems significantly interfered with your work, school or social activities, or caused significant distress?

I. ALCOHOL DEPENDENCE / ABUSE

(➡ MEANS: GO TO DIAGNOSTIC BOXES, CIRCLE NO IN BOTH AND MOVE TO THE NEXT MODULE)

		➡	
I1	**In the past 12 months**, have you had 3 or more alcoholic drinks, - within a 3 hour period, - on 3 or more occasions?	NO	YES

I2   **In the past 12 months**:

a	Did you need to drink a lot more in order to get the same effect that you got when you first started drinking or did you get much less effect with continued use of the same amount?	NO	YES
b	When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms (for example, "the shakes", sweating or agitation) or to avoid being hungover? IF **YES** TO ANY, CODE **YES**.	NO	YES
c	During the times when you drank alcohol, did you end up drinking more than you planned when you started?	NO	YES
d	Have you tried to reduce or stop drinking alcohol but failed?	NO	YES
e	On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?	NO	YES
f	Did you spend less time working, enjoying hobbies, or being with others because of your drinking?	NO	YES
g	If your drinking caused you health or mental problems, did you still keep on drinking?	NO	YES

ARE **3** OR MORE **I2** ANSWERS CODED **YES**?

∗ IF YES, SKIP I3 QUESTIONS AND GO TO NEXT MODULE. "DEPENDENCE PREEMPTS ABUSE" IN DSM IV TR.

> **NO   YES∗**
>
> *ALCOHOL DEPENDENCE*
> **CURRENT**

I3   **In the past 12 months:**

a	Have you been intoxicated, high, or hungover more than once when you had other responsibilities at school, at work, or at home? Did this cause any problems? (CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)	NO	YES
b	Were you intoxicated more than once in any situation where you were physically at risk, for example, driving a car, riding a motorbike, using machinery, boating, etc.?	NO	YES
c	Did you have legal problems more than once because of your drinking, for example, an arrest or disorderly conduct?	NO	YES
d	If your drinking caused problems with your family or other people, did you still keep on drinking?	NO	YES

ARE **1** OR MORE **I3** ANSWERS CODED **YES**?

NO	YES
ALCOHOL ABUSE	
CURRENT	

J. SUBSTANCE DEPENDENCE / ABUSE (NON-ALCOHOL)

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

Now I am going to show you / read to you a list of street drugs or medicines.	➡	
J1 a **In the past 12 months**, did you take any of these drugs more than once, to get high, to feel elated, to get "a buzz" or to change your mood?	NO	YES

CIRCLE EACH DRUG TAKEN:

Stimulants: amphetamines, "speed", crystal meth, "crank", "rush", Dexedrine, Ritalin, diet pills.

Cocaine: snorting, IV, freebase, crack, "speedball".

Narcotics: heroin, morphine, Dilaudid, opium, Demerol, methadone, Darvon, codeine, Percodan, Vicoden, OxyContin.

Hallucinogens: LSD ("acid"), mescaline, peyote, psilocybin, STP, "mushrooms", "ecstasy", MDA, MDMA.

Phencyclidine: PCP ("Angel Dust", "PeaCe Pill", "Tranq", "Hog"), or ketamine ("special K").

Inhalants: "glue", ethyl chloride, "rush", nitrous oxide ("laughing gas"), amyl or butyl nitrate ("poppers").

Cannabis: marijuana, hashish ("hash"), THC, "pot", "grass", "weed", "reefer".

Tranquilizers: Quaalude, Seconal ("reds"), Valium, Xanax, Librium, Ativan, Dalmane, Halcion, barbiturates, Miltown, GHB, Roofinol, "Roofies".

Miscellaneous: steroids, nonprescription sleep or diet pills. Cough Medicine? Any others?

SPECIFY THE MOST USED DRUG(S): _____

WHICH DRUG(S) CAUSE THE BIGGEST PROBLEMS?: _____

FIRST EXPLORE THE DRUG CAUSING THE BIGGEST PROBLEMS AND MOST LIKELY TO MEET DEPENDENCE / ABUSE CRITERIA.

IF MEETS CRITERIA FOR ABUSE OR DEPENDENCE, SKIP TO THE NEXT MODULE. OTHERWISE, EXPLORE THE NEXT MOST PROBLEMATIC DRUG.

J2   **Considering your use of (NAME THE DRUG / DRUG CLASS SELECTED), in the past 12 months:**

a	Have you found that you needed to use much more (NAME OF DRUG / DRUG CLASS SELECTED) to get the same effect that you did when you first started taking it?	NO	YES
b	When you reduced or stopped using (NAME OF DRUG / DRUG CLASS SELECTED), did you have withdrawal symptoms (aches, shaking, fever, weakness, diarrhea, nausea, sweating, heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Did you use any drug(s) to keep yourself from getting sick (withdrawal symptoms) or so that you would feel better? IF **YES** TO EITHER, CODE **YES**.	NO	YES
c	Have you often found that when you used (NAME OF DRUG / DRUG CLASS SELECTED), you ended up taking more than you thought you would?	NO	YES
d	Have you tried to reduce or stop taking (NAME OF DRUG / DRUG CLASS SELECTED) but failed?	NO	YES
e	On the days that you used (NAME OF DRUG / DRUG CLASS SELECTED), did you spend substantial time (>2 HOURS), obtaining, using or in recovering from the drug, or thinking about the drug?	NO	YES
f	Did you spend less time working, enjoying hobbies, or being with family or friends because of your drug use?	NO	YES
g	If (NAME OF DRUG / DRUG CLASS SELECTED) caused you health or mental problems, did you still keep on using it?	NO	YES

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ARE **3** OR MORE **J2** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

* IF YES, SKIP J3 QUESTIONS, MOVE TO NEXT DISORDER.
"DEPENDENCE PREEMPTS ABUSE" IN DSM IV TR.

NO	YES *****
SUBSTANCE DEPENDENCE	
CURRENT	

Considering your use of (NAME THE DRUG CLASS SELECTED), in the past 12 months:

J3 a Have you been intoxicated, high, or hungover from (NAME OF DRUG / DRUG CLASS SELECTED)   NO   YES
more than once, when you had other responsibilities at school, at work, or at home?
Did this cause any problem?

(CODE **YES** ONLY IF THIS CAUSED PROBLEMS.)

b Have you been high or intoxicated from (NAME OF DRUG / DRUG CLASS SELECTED)   NO   YES
more than once in any situation where you were physically at risk (for example,
driving a car, riding a motorbike, using machinery, boating, etc.)?

c Did you have legal problems more than once because of your drug use, for example,   NO   YES
an arrest or disorderly conduct?

d If (NAME OF DRUG / DRUG CLASS SELECTED) caused problems   NO   YES
with your family or other people, did you still keep on using it?

ARE **1** OR MORE **J3** ANSWERS CODED **YES**?

SPECIFY DRUG(S): _____

NO	YES
SUBSTANCE ABUSE	
CURRENT	

K. PSYCHOTIC DISORDERS AND MOOD DISORDER WITH PSYCHOTIC FEATURES

ASK FOR AN EXAMPLE OF EACH QUESTION ANSWERED POSITIVELY. CODE **YES** ONLY IF THE EXAMPLES CLEARLY SHOW A DISTORTION OF THOUGHT OR OF PERCEPTION OR IF THEY ARE NOT CULTURALLY APPROPRIATE. BEFORE CODING, INVESTIGATE WHETHER DELUSIONS QUALIFY AS "BIZARRE".

DELUSIONS ARE "BIZARRE" IF: CLEARLY IMPLAUSIBLE, ABSURD, NOT UNDERSTANDABLE, AND CANNOT DERIVE FROM ORDINARY LIFE EXPERIENCE.
HALLUCINATIONS ARE SCORED "BIZARRE" IF: A VOICE COMMENTS ON THE PERSON'S THOUGHTS OR BEHAVIOR, OR WHEN TWO OR MORE VOICES ARE CONVERSING WITH EACH OTHER.
THE PURPOSE OF THIS MODULE IS TO EXCLUDE PATIENTS WITH PSYCHOTIC DISORDERS. THIS MODULE NEEDS EXPERIENCE.

		Now I am going to ask you about unusual experiences that some people have.			BIZARRE
K1	a	Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? **NOTE**: ASK FOR EXAMPLES TO RULE OUT ACTUAL STALKING.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ↳**K6**
K2	a	Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ↳**K6**
K3	a	Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Have you ever felt that you were possessed? CLINICIAN: ASK FOR EXAMPLES AND DISCOUNT ANY THAT ARE NOT PSYCHOTIC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ↳**K6**
K4	a	Have you ever believed that you were being sent special messages through the TV, radio, newspapers, books or magazines or that a person you did not personally know was particularly interested in you?	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do you currently believe these things?	NO	YES	YES ↳**K6**
K5	a	Have your relatives or friends ever considered any of your beliefs odd or unusual? INTERVIEWER**:** ASK FOR EXAMPLES. ONLY CODE **YES** IF THE EXAMPLES ARE **CLEARLY** DELUSIONAL IDEAS NOT EXPLORED IN QUESTIONS K1 TO K4, FOR EXAMPLE, SOMATIC OR RELIGIOUS DELUSIONS OR DELUSIONS OF GRANDIOSITY, JEALOUSY, GUILT, RUIN OR DESTITUTION, ETC.	NO	YES	YES
	b	**IF YES OR YES BIZARRE:** do they currently consider your beliefs strange?	NO	YES	YES
K6	a	Have you ever heard things other people couldn't hear, such as voices?	NO	YES	
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES
	b	**IF YES OR YES BIZARRE TO K6a:** have you heard sounds / voices in the past month?	NO	YES	
		IF YES TO VOICE HALLUCINATION: Was the voice commenting on your thoughts or behavior or did you hear two or more voices talking to each other?	NO		YES ↳**K8b**

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K7 a Have you ever had visions when you were awake or have you ever seen things other people couldn't see?

CLINICIAN: CHECK TO SEE IF THESE ARE CULTURALLY INAPPROPRIATE.

NO   YES

b **IF YES:** have you seen these things in the past month?

NO   YES

CLINICIAN'S JUDGMENT

K8 b IS THE PATIENT CURRENTLY EXHIBITING INCOHERENCE, DISORGANIZED SPEECH, OR MARKED LOOSENING OF ASSOCIATIONS?

NO   YES

K9 b IS THE PATIENT CURRENTLY EXHIBITING DISORGANIZED OR CATATONIC BEHAVIOR?

NO   YES

K10 b ARE NEGATIVE SYMPTOMS OF SCHIZOPHRENIA, E.G. SIGNIFICANT AFFECTIVE FLATTENING, POVERTY OF SPEECH (ALOGIA) OR AN INABILITY TO INITIATE OR PERSIST IN GOAL-DIRECTED ACTIVITIES (AVOLITION), PROMINENT DURING THE INTERVIEW?

NO   YES

K11 a ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K7a CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT, RECURRENT OR PAST)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT OR PAST) CODED **YES**?

NO   YES
↳ **K13**

IF NO TO K11 a, CIRCLE NO IN BOTH 'MOOD DISORDER WITH PSYCHOTIC FEATURES' DIAGNOSTIC BOXES AND MOVE TO K13.

b You told me earlier that you had period(s) when you felt (depressed/high/persistently irritable).

Were the beliefs and experiences you just described (SYMPTOMS CODED **YES** FROM **K1**a TO **K7**a) restricted exclusively to times when you were feeling depressed/high/irritable?

IF THE PATIENT EVER HAD A PERIOD OF AT LEAST 2 WEEKS OF HAVING THESE BELIEFS OR EXPERIENCES (PSYCHOTIC SYMPTOMS) WHEN THEY WERE NOT DEPRESSED/HIGH/IRRITABLE, CODE NO TO THIS DISORDER.

IF THE ANSWER IS NO TO THIS DISORDER, ALSO CIRCLE NO TO K12 AND MOVE TO K13

NO	**YES**
MOOD DISORDER WITH PSYCHOTIC FEATURES	
LIFETIME	

K12 a ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K7b CODED **YES OR YES BIZARRE** AND IS EITHER:

MAJOR DEPRESSIVE EPISODE, (CURRENT)
OR
MANIC OR HYPOMANIC EPISODE, (CURRENT) CODED **YES**?

IF THE ANSWER IS YES TO THIS DISORDER (LIFETIME OR CURRENT), CIRCLE NO TO K13 AND K14 AND MOVE TO THE NEXT MODULE.

NO	**YES**
MOOD DISORDER WITH PSYCHOTIC FEATURES	
CURRENT	

K13   ARE 1 OR MORE « b » QUESTIONS FROM K1b TO K6b, CODED **YES BIZARRE**?

    OR

ARE 2 OR MORE « b » QUESTIONS FROM K1b TO K10b, CODED **YES** (RATHER THAN **YES BIZARRE**)?

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO	YES
PSYCHOTIC DISORDER **CURRENT**	

K14   IS **K13** CODED **YES**

    OR

ARE 1 OR MORE « a » QUESTIONS FROM K1a TO K6a, CODED **YES BIZARRE**?

    OR

ARE 2 OR MORE « a » QUESTIONS FROM K1a TO K7a, CODED **YES** (RATHER THAN **YES BIZARRE**)

AND DID AT LEAST TWO OF THE PSYCHOTIC SYMPTOMS OCCUR DURING THE SAME 1 MONTH PERIOD?

NO	YES
PSYCHOTIC DISORDER **LIFETIME**	

L. ANOREXIA NERVOSA

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE **NO**, AND MOVE TO THE NEXT MODULE)

L1	a	How tall are you?	☐ft ☐☐in.
			☐ ☐ ☐cm.
	b.	What was your lowest weight in the past 3 months?	☐ ☐ ☐lbs.
			☐ ☐ ☐kgs.
	c	IS PATIENT'S WEIGHT EQUAL TO OR BELOW THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? (SEE TABLE BELOW)	➡ NO YES

In the past 3 months:

L2		In spite of this low weight, have you tried not to gain weight?	➡ NO YES
L3		Have you intensely feared gaining weight or becoming fat, even though you were underweight?	➡ NO YES
L4	a	Have you considered yourself too big / fat or that part of your body was too big / fat?	NO YES
	b	Has your body weight or shape greatly influenced how you felt about yourself?	NO YES
	c	Have you thought that your current low body weight was normal or excessive?	NO YES
L5		ARE 1 OR MORE ITEMS FROM **L4** CODED **YES**?	➡ NO YES
L6		FOR WOMEN ONLY: During the last 3 months, did you miss all your menstrual periods when they were expected to occur (when you were not pregnant)?	➡ NO YES

FOR WOMEN: ARE **L5 AND L6** CODED **YES**?

FOR MEN: IS **L5** CODED **YES**?

NO	YES
ANOREXIA NERVOSA **CURRENT**	

HEIGHT / WEIGHT TABLE CORRESPONDING TO A BMI THRESHOLD OF 17.5 KG/M^2

Height/Weight														
ft/in	4'9	4'10	4'11	5'0	5'1	5'2	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10
lbs.	81	84	87	89	92	96	99	102	105	108	112	115	118	122
cm	145	147	150	152	155	158	160	163	165	168	170	173	175	178
kgs	37	38	39	41	42	43	45	46	48	49	51	52	54	55

Height/Weight				
ft/in	5'11	6'0	6'1	6'2	6'3
lbs.	125	129	132	136	140
cm	180	183	185	188	191
kgs	57	59	60	62	64

The weight thresholds above are calculated using a body mass index (BMI) equal to or below 17.5 kg/m^2 for the patient's height. This is the threshold guideline below which a person is deemed underweight by the DSM-IV and the ICD-10 Diagnostic Criteria for Research for Anorexia Nervosa.

M. BULIMIA NERVOSA

(➡ MEANS : GO TO THE DIAGNOSTIC BOXES, CIRCLE NO IN ALL DIAGNOSTIC BOXES, AND MOVE TO THE NEXT MODULE)

M1	In the past three months, did you have eating binges or times when you ate a very large amount of food within a 2-hour period?	➡ NO	YES
M2	In the last 3 months, did you have eating binges as often as twice a week?	➡ NO	YES

M3	During these binges, did you feel that your eating was out of control?	➡ NO	YES
M4	Did you do anything to compensate for, or to prevent a weight gain from these binges, like vomiting, fasting, exercising or taking laxatives, enemas, diuretics (fluid pills), or other medications?	➡ NO	YES
M5	Does your body weight or shape greatly influence how you feel about yourself?	➡ NO	YES
M6	DO THE PATIENT'S SYMPTOMS MEET CRITERIA FOR ANOREXIA NERVOSA?	NO ↓ Skip to M8	YES
M7	Do these binges occur only when you are under (_____ lbs./kgs.)? INTERVIEWER: WRITE IN THE ABOVE PARENTHESIS THE THRESHOLD WEIGHT FOR THIS PATIENT'S HEIGHT FROM THE HEIGHT / WEIGHT TABLE IN THE ANOREXIA NERVOSA MODULE.	NO	YES

M8   IS **M5** CODED **YES** AND IS EITHER **M6** OR **M7** CODED **NO**?

```
┌─────────────────────────────┐
│   NO              YES        │
│                             │
│      BULIMIA NERVOSA        │
│         CURRENT             │
└─────────────────────────────┘
```

IS **M7** CODED **YES**?

```
┌─────────────────────────────┐
│   NO              YES        │
│                             │
│     ANOREXIA NERVOSA        │
│   Binge Eating/Purging Type │
│         CURRENT             │
└─────────────────────────────┘
```

N. GENERALIZED ANXIETY DISORDER

(➡ MEANS : GO TO THE DIAGNOSTIC BOX, CIRCLE NO, AND MOVE TO THE NEXT MODULE)

N1	a	Were you excessively anxious or worried about several routine things, over the past 6 months? IN ENGLISH, IF THE PATIENT IS UNCLEAR ABOUT WHAT YOU MEAN, PROBE BY ASKING (Do others think that you are a "worry wart") AND GET EXAMPLES.	➡ NO	YES
	b	Are these anxieties and worries present most days?	➡ NO	YES
		ARE THE PATIENT'S ANXIETY AND WORRIES RESTRICTED EXCLUSIVELY TO, OR BETTER EXPLAINED BY, ANY DISORDER PRIOR TO THIS POINT?	NO	➡ YES
N2		Do you find it difficult to control the worries?	➡ NO	YES

N3 FOR THE FOLLOWING, CODE **NO** IF THE SYMPTOMS ARE CONFINED TO
FEATURES OF ANY DISORDER EXPLORED PRIOR TO THIS POINT**.**

When you were anxious over the past 6 months, did you, most of the time:

a	Feel restless, keyed up or on edge?	NO	YES
b	Have muscle tension?	NO	YES
c	Feel tired, weak or exhausted easily?	NO	YES
d	Have difficulty concentrating or find your mind going blank?	NO	YES
e	Feel irritable?	NO	YES
f	Have difficulty sleeping (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?	NO	YES
	ARE **3** OR MORE **N3** ANSWERS CODED **YES?**	➡ NO	YES

N4 Do these anxieties and worries disrupt your normal work, school or
social functioning or cause you significant distress?

```
┌─────────────────────────────┐
│   NO              YES        │
│                             │
│  GENERALIZED ANXIETY        │
│       DISORDER              │
│      CURRENT                │
└─────────────────────────────┘
```

O. RULE OUT MEDICAL, ORGANIC OR DRUG CAUSES FOR ALL DISORDERS

IF THE PATIENT CODES POSITIVE FOR ANY CURRENT DISORDER ASK:

Just before these symptoms began:

O1a	Were you taking any drugs or medicines?	❏ No	❏ Yes	❏ Uncertain
O1b	Did you have any medical illness?	❏ No	❏ Yes	❏ Uncertain

IN THE CLINICIAN'S JUDGMENT: ARE EITHER OF THESE LIKELY TO BE DIRECT CAUSES OF THE PATIENT'S DISORDER?
IF NECESSARY ASK ADDITIONAL OPEN-ENDED QUESTIONS.

O2	**SUMMARY**: HAS AN ORGANIC CAUSE BEEN RULED OUT?	❏ No	❏ Yes	❏ Uncertain

P. ANTISOCIAL PERSONALITY DISORDER

(➡ MEANS : GO TO THE DIAGNOSTIC BOX AND CIRCLE NO)

P1   **Before you were 15 years old, did you:**

a   repeatedly skip school or run away from home overnight?   NO   YES

b   repeatedly lie, cheat, "con" others, or steal?   NO   YES

c   start fights or bully, threaten, or intimidate others?   NO   YES

d   deliberately destroy things or start fires?   NO   YES

e   deliberately hurt animals or people?   NO   YES

f   force someone to have sex with you?   NO   YES
                                                                                     ➡
    ARE **2** OR MORE **P1** ANSWERS CODED **YES**?   NO   YES

    DO NOT CODE **YES** TO THE BEHAVIORS BELOW IF THEY ARE EXCLUSIVELY
    POLITICALLY OR RELIGIOUSLY MOTIVATED**.**

P2   **Since you were 15 years old, have you:**

a   repeatedly behaved in a way that others would consider irresponsible, like   NO   YES
    failing to pay for things you owed, deliberately being impulsive or deliberately
    not working to support yourself?

b   done things that are illegal even if you didn't get caught (for example, destroying   NO   YES
    property, shoplifting, stealing, selling drugs, or committing a felony)?

c   been in physical fights repeatedly (including physical fights with your   NO   YES
    spouse or children)?

d   often lied or "conned" other people to get money or pleasure, or lied just   NO   YES
    for fun?

e   exposed others to danger without caring?   NO   YES

f   felt no guilt after hurting, mistreating, lying to, or stealing from others, or NO   YES
    after damaging property?

ARE **3** OR MORE **P2** QUESTIONS CODED **YES**?

NO	YES
ANTISOCIAL PERSONALITY DISORDER	
LIFETIME	

THIS CONCLUDES THE INTERVIEW

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Translations	M.I.N.I. 4.4 or earlier versions	M.I.N.I. 4.6/5.0, M.I.N.I. Plus 4.6/5.0 and M.I.N.I. Screen 5.0:
Afrikaans	R. Emsley, W. Maartens	
Arabic		O. Osman, E. Al-Radi
Bengali		H. Banerjee, A. Banerjee
Braille (English)		
Brazilian Portuguese	P. Amorim	P. Amorim
Bulgarian	L.G. Hranov	
Chinese		L. Carroll, Y-J. Lee, Y-S. Chen, C-C. Chen, C-Y. Liu, C-K. Wu, H-S. Tang, K-D. Juang, Yan-Ping Zheng.
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English	D. Sheehan, J. Janavs, R. Baker, K. Harnett-Sheehan, E. Knapp, M. Sheehan	D. Sheehan, R. Baker, J. Janavs, K. Harnett-Sheehan, M. Sheehan
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Finnish	M. Heikkinen, M. Lijeström, O. Tuominen	M. Heikkinen, M. Lijeström, O. Tuominen
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Gujarati		M. Patel, B. Patel, Organon
Hebrew	J. Zohar, Y. Sasson	R. Barda, I. Levinson, A. Aviv
Hindi		C. Mittal, K. Batra, S. Gambhir, Organon
Hungarian	I. Bitter, J. Balazs	I. Bitter, J. Balazs
Icelandic		J.G. Stefansson
Italian	I. Bonora, L. Conti, M. Piccinelli, M. Tansella, G. Cassano, Y. Lecrubier, P. Donda, E. Weiller	L. Conti, A. Rossi, P. Donda
Japanese		T. Otsubo, H. Watanabe, H. Miyaoka, K. Kamijima, J.Shinoda, K.Tanaka, Y. Okajima

Kannada		Organon
Korean		K.S. Oh and Korean Academy of Anxiety Disorders
Latvian	V. Janavs, J. Janavs, I. Nagobads	V. Janavs, J. Janavs
Lithuanian		A. Bacevicius
Luganda		WW. Muhweziosal, H. Agren
Malayalam		Organon
Marathi		Organon
Norwegian	G. Pedersen, S. Blomhoff	K.A. Leiknes , U. Malt, E. Malt, S. Leganger
Polish	M. Masiak, E. Jasiak	M. Masiak, E. Jasiak
Portuguese	P. Amorim	P. Amorim, T. Guterres
Punjabi		A. Gahunia, S. Gambhir
Romanian		O. Driga
Russian		A. Bystritsky, E. Selivra, M. Bystritsky, L. Shumyak, M. Klisinska.
Serbian	I. Timotijevic	I. Timotijevic
Setswana	K. Ketlogetswe	
Slovenian	M. Kocmur	
Spanish	L. Ferrando, J. Bobes-Garcia, J. Gilbert-Rahola, Y. Lecrubier	L. Ferrando, L. Franco-Alfonso, M. Soto, J. Bobes-Garcia, O. Soto, L. Franco, G. Heinze, C. Santana, R. Hidalgo
Swedish	M. Waern, S. Andersch, M. Humble	C. Allgulander, H. Agren M. Waern, A. Brimse, M. Humble.
Tamil		Organon
Telugu		Organon
Thai		P. Kittirattanapaiboon, S. Mahatnirunkul, P. Udomrat, P. Silpakit,, M. Khamwongpin, S. Srikosai.
Turkish	T. Örnek, A. Keskiner, I. Vahip	T. Örnek, A. Keskiner, A.Engeler
Urdu		S. Gambhir
Yiddish		J. Goldman, Chana Pollack, Myrna Mniewski

MOOD DISORDERS: DIAGNOSTIC ALGORITHM

Consult Modules:
  A   Major Depressive Episode
  C   (Hypo) manic Episode
  K   Psychotic Disorders

MODULE K:

			NO	YES
1a	IS **K11b** CODED YES?		NO	YES
1b	IS **K12a** CODED YES?		NO	YES

MODULES A and C: Current   Past

2   a   CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **A3e**?   YES   YES

    b   CIRCLE YES IF A DELUSIONAL IDEA IS IDENTIFIED IN **C3a**?   YES   YES

c   Is a Major Depressive Episode coded YES (current or past)?
      and
    is Manic Episode coded NO (current and past)?
      and
    is Hypomanic Episode coded NO (current and past)?
      and
    is **"**Hypomanic Symptoms" coded NO (current and past)?

    Specify:
    - If the depressive episode is **current** or **past** or both

    - **With Psychotic Features** Current: If 1b or 2a (current) = YES
      With Psychotic Features Past: If 1a or 2a (past) = YES

> *MAJOR DEPRESSIVE*
> *DISORDER*
>
> current   past
> **MDD**   ❏   ❏
>
> *With Psychotic Features*
> Current   ❏
> Past   ❏

d   Is a Manic Episode coded YES (current or past)?

    Specify:

    - If the Bipolar I Disorder is **current** or **past** or both

    - With **Single Manic Episode**: If Manic episode (current or past) = YES
      and MDE (current and past) = NO

    - **With Psychotic Features** Current: If 1b or 2a (current) or 2b (current) = YES
      With Psychotic Features Past: If 1a or 2a (past) or 2b (past) = YES

    - If the **most recent episode** is manic, depressed,
      mixed or hypomanic or unspecified (all mutually exclusive)

    - **Unspecified** if the Past Manic Episode is coded YES AND
      Current (C3 Summary AND C4a AND C6 AND O2) are coded YES

> *BIPOLAR I*
> *DISORDER*
>
> current   past
> **Bipolar I Disorder**   ❏   ❏
> Single Manic Episode   ❏   ❏
>
> *With Psychotic Features*
> Current   ❏
> Past   ❏
>
> *Most Recent Episode*
> Manic   ❏
> Depressed   ❏
> Mixed   ❏
> Hypomanic   ❏
> Unspecified   ❏

e   Is Major Depressive Episode coded YES (current or past)?
     and
    Is Hypomanic Episode coded YES (current or past)?
     and
    Is Manic Episode coded NO (current and past)?

    Specify:

    • If the Bipolar Disorder is **current** or **past** or both

    • If the most recent mood episode is **hypomanic** or **depressed** (mutually exclusive)

<div style="border:1px solid black;">

BIPOLAR II DISORDER

              current past
Bipolar II Disorder ❏   ❏

Most Recent Episode

Hypomanic   ❏
Depressed   ❏

</div>

f   Is MDE coded NO (current and past)
       and
    Is Manic Episode coded NO (current and past)?
       and is either:

  1)   C7b coded YES for the appropriate time frame?

      or

  2)   C3 Summary coded YES for the appropriate time frame?
      and
    C4a coded YES for the appropriate time frame?
      and
    C7c coded YES for the appropriate time frame?

   Specify if the Bipolar Disorder NOS is **current** or **past** or both

<div style="border:1px solid black;">

BIPOLAR DISORDER NOS

              current   past
Bipolar Disorder NOS ❏   ❏

</div>

M.I.N.I. PLUS

The shaded modules below are additional modules available in the MINI PLUS beyond what is available in the standard MINI. The un-shaded modules below are in the standard MINI.

These MINI PLUS modules can be inserted into or used in place of the standard MINI modules, as dictated by the specific needs of any study.

	MODULES	TIME FRAME
A	MAJOR DEPRESSIVE EPISODE	Current (2 weeks) Past Recurrent
	MOOD DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current Past
	SUBSTANCE INDUCED MOOD DISORDER	Current Past
	MDE WITH MELANCHOLIC FEATURES	Current (2 weeks)
	MDE WITH ATYPICAL FEATURES	Current (2 weeks)
	MDE WITH CATATONIC FEATURES	Current (2 weeks)
B	DYSTHYMIA	Current (Past 2 years) Past
C	SUICIDALITY	Current (Past Month) Risk: ❑ Low ❑ Medium ❑ High
D	MANIC EPISODE	Current Past
	HYPOMANIC EPISODE	Current Past
	BIPOLAR I DISORDER	Current Past
	BIPOLAR II DISORDER	Current Past
	BIPOLAR DISORDER NOS	Current Past
	MANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current Past
	HYPOMANIC EPISODE DUE TO A GENERAL MEDICAL CONDITION	Current Past
	SUBSTANCE INDUCED MANIC EPISODE	Current Past
	SUBSTANCE INDUCED HYPOMANIC EPISODE	Current Past
E	PANIC DISORDER	Current (Past Month) Lifetime
	ANXIETY DISORDER WITH PANIC ATTACKS DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED ANXIETY DISORDER WITH PANIC ATTACKS	Current
F	AGORAPHOBIA	Current
G	SOCIAL PHOBIA (Social Anxiety Disorder)	Current (Past Month)
H	SPECIFIC PHOBIA	Current
I	OBSESSIVE-COMPULSIVE DISORDER	Current (Past Month)
	OCD DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED OCD	Current
J	POSTTRAUMATIC STRESS DISORDER	Current (Past Month)
K	ALCOHOL DEPENDENCE	Past 12 Months
	ALCOHOL DEPENDENCE	Lifetime
	ALCOHOL ABUSE	Past 12 Months
	ALCOHOL ABUSE	Lifetime
L	SUBSTANCE DEPENDENCE (Non-alcohol)	Past 12 Months
	SUBSTANCE DEPENDENCE (Non-alcohol)	Lifetime
	SUBSTANCE ABUSE (Non-alcohol)	Past 12 Months

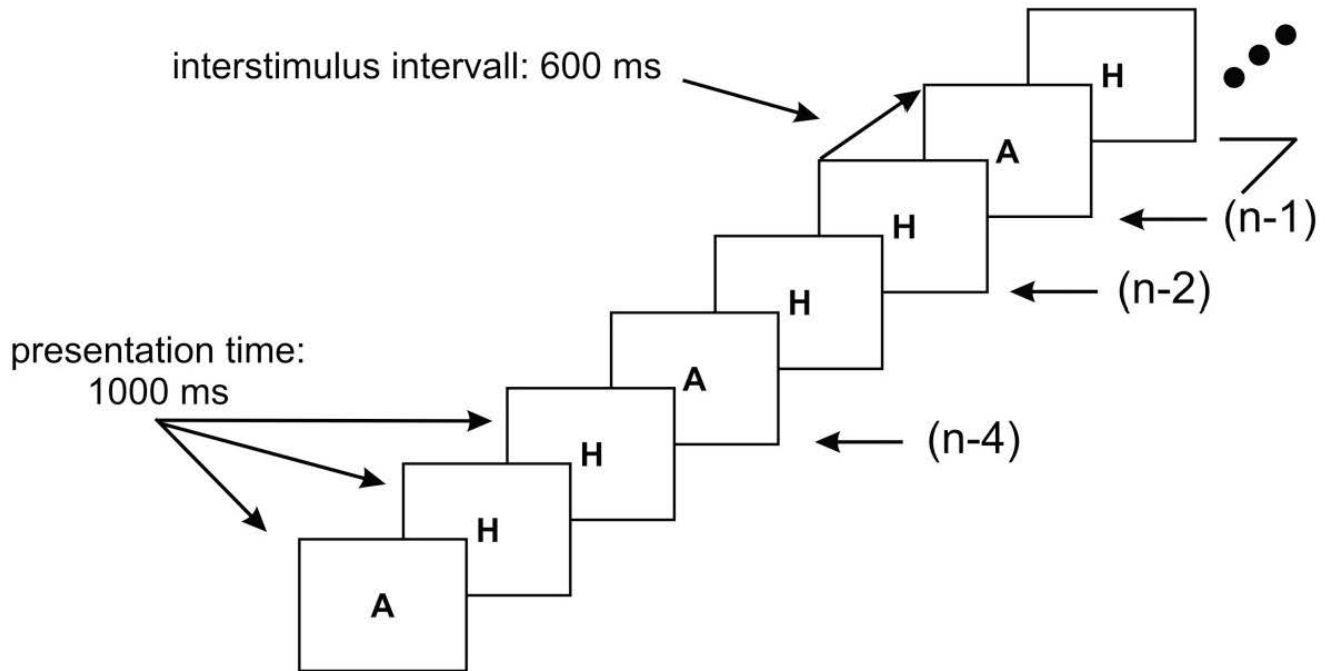|		
M	PSYCHOTIC DISORDERS	Lifetime
		Current
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Current
	SCHIZOPHRENIA	Current
		Lifetime
	SCHIZOAFFECTIVE DISORDER	Current
		Lifetime
	SCHIZOPHRENIFORM DISORDER	Current
		Lifetime
	BRIEF PSYCHOTIC DISORDER	Current
		Lifetime
	DELUSIONAL DISORDER	Current
		Lifetime
	PSYCHOTIC DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current
		Lifetime
	SUBSTANCE INDUCED PSYCHOTIC DISORDER	Current
		Lifetime
	PSYCHOTIC DISORDER NOS	Current
		Lifetime
	MOOD DISORDER WITH PSYCHOTIC FEATURES	Lifetime
	MOOD DISORDER NOS	Lifetime
	MAJOR DEPRESSIVE DISORDER WITH PSYCHOTIC FEATURES	Current
		Past
	BIPOLAR I DISORDER WITH PSYCHOTIC FEATURES	Current
		Past
N	ANOREXIA NERVOSA	Current (Past 3 Months)
O	BULIMIA NERVOSA	Current (Past 3 Months)
	BULIMIA NERVOSA PURGING TYPE	Current
	BULIMIA NERVOSA NONPURGING TYPE	Current
	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE	Current
	ANOREXIA NERVOSA, RESTRICTING TYPE	Current
P	GENERALIZED ANXIETY DISORDER	Current (Past 6 Months)
	GENERALIZED ANXIETY DISORDER DUE TO A GENERAL MEDICAL CONDITION	Current
	SUBSTANCE INDUCED GAD	Current
Q	ANTISOCIAL PERSONALITY DISORDER	Lifetime
R	SOMATIZATION DISORDER	Lifetime
		Current
S	HYPOCHONDRIASIS	Current
T	BODY DYSMORPHIC DISORDER	Current
U	PAIN DISORDER	Current
V	CONDUCT DISORDER	Past 12 Months
W	ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Children/Adolescents)	Past 6 Months
	ATTENTION DEFICIT/HYPERACTIVITY DISORDER (Adults)	Lifetime
		Current
X	ADJUSTMENT DISORDERS	Current
Y	PREMENSTRUAL DYSPHORIC DISORDER	Current
Z	MIXED ANXIETY-DEPRESSIVE DISORDER	Current

Multi-Source Interference Task (MSIT)

Control

Interference

100

221

N-back task

interstimulus intervall: 600 ms

presentation time: 1000 ms

(n-1)

(n-2)

(n-4)

Please put an **X** next to the statement that best describes how you feel:

Right now I am:

☐ Feeling active, vital, alert or wide awake

☐ Functioning at high levels, but not at peak; able to concentrate

☐ Awake, but relaxed; responsive but not fully alert

☐ Somewhat foggy, let down

☐ Foggy; losing interest in remaining awake; slowed down

☐ Sleepy, woozy, fighting sleep; prefer to lie down

☐ No longer fighting sleep, sleep onset soon; having dream-like thoughts

❖ Asleep

Automated Neuropsychological Assessment Metrics (ANAM4)

Directed Attention

5 + 8 - 9

Manikin Test   Math Processing

Tower Puzzle

Time Left
Shows
Score
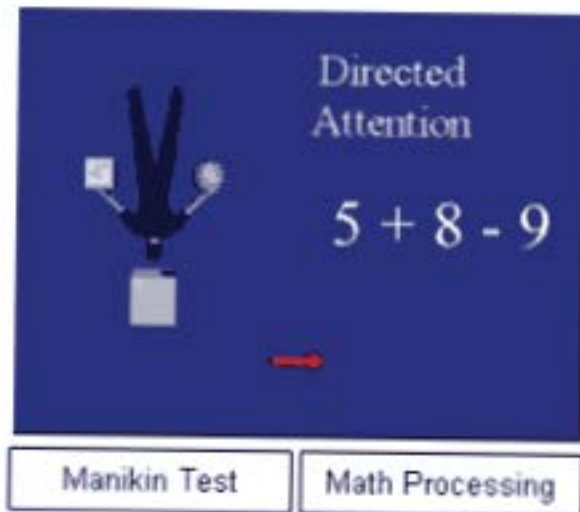
Psychomotor Vigilance Test

Press the spacebar every time an "x" appears on the screen.

10-20 PSG electrode attachments

Subject ID: _____   Date: _____

	Measure	cm	Electrode	Distance	cm	Completed
1	Nasion to Inion		**CZ**	midpoint		
			FP	10% from nasion		
			OZ	10% from inion		
2	Preaurical to preaurical		**CZ**	midpoint		
			C3 & C4	20% from midpoint		
3	Head Circumference (through FP and OZ)		**FP1 & FP2**	5% to each side of FP		
			O1 & O2	5% to each side of OZ		
4	FP1 to C3		**F3**	50% from C3		
5	FP2 to C4		**F4**	50% from C4		
6	Reference		**A1 & A2**			
7	Chins (EMG)		**EMG1 & EMG2**			

Bio Calibrations

	Instruction	Code	Duration	MSLT 1 Completed	MSLT 2 Completed	MSLT 3 Completed
1	Rest with eyes open	EO	1 min (2 epochs)			
2	Rest with eyes closed	EC	1 min (2 epochs)			
3	Look up and down	U/D	30 sec (1 epoch)			
4	Look left and right	L/R	30 sec (1 epoch)			
5	Blink 5 times	Blink	5 blinks (1 epoch)			
6	Grit teeth	Teeth	30 sec (1 epoch)			

	MSLT 1	MSLT 2	MSLT 3
Lights out epoch			
Wake time epoch			

Subject: _____   Date:_____

Read the following scenarios. Each scenario presents a situation and asks a question about the chance or likelihood that you would experience a particular outcome. For each one, think about how likely that outcome would be for YOU in that situation. Do NOT worry about how most people would do in a particular situation—just think about the chance that a particular outcome would happen to YOU in that situation. Circle the percent chance that best represents the probability that the outcome would happen to YOU.

1. You arrive 25 minutes late for a big job interview. What is the probability that YOU will get the job?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

2. If you were to find yourself confronted by a vicious angry dog, what is the probability that YOU could get away unharmed?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

3. Regardless of your moral convictions, if you were to shoplift a pair of $50 sunglasses from a chain drug store, what is the probability that YOU could get away with it without being caught?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

4. While leaving a popular night club, you are attacked by a drunk man in his early 20s wielding a 10 inch knife. During the scuffle, your friend is stabbed, but not fatally. What is the chance that YOU will be killed during the attack?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

5. While on vacation, you meet up with a stranger asking for help. Although the story the stranger tells you is heart wrenching and he seems very sincere, you are aware that he may just be a con-artist trying to scam you. If the stranger truly is a con-artist, what is the probability YOU will end up being scammed out of some of your money?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

6. You awaken one morning realizing that you engaged in unprotected sex with someone you just met. Now that the alcohol has worn off, your partner remorsefully tells you that he/she has suffered for a long time with a very serious sexually transmitted disease. What is the chance that YOU will contract the sexually transmitted disease yourself after this contact?

   0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

7. While on vacation in a far away country, your 3 traveling companions have all contracted a bad case of diarrhea after drinking the water. You realize that you just drank some of the same water about an hour ago. What is the likelihood that YOU will come down with diarrhea too?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

8. While on vacation in the woods, you decide to go hiking in an unfamiliar and thickly wooded area without a map or guide. What is the likelihood that YOU will get lost?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

9. You have been at a nightclub for 4 hours. During that time you have had 7 alcoholic beverages. You are feeling a little "buzzed" but you decide to drive yourself home anyway because it is only about 5 miles away. What is the probability that YOU will make it home without any negative incident?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

10. While playing golf one afternoon a thunderstorm comes up quickly. There is much wind and occasional lightning is hitting nearby. Because you are winning the game and only have two more holes to play, you decide to continue to the end. What is the likelihood that YOU will be struck by lightning before finishing the game?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

11. While at your job you discover that one of your superiors has been embezzling large amounts of money from your organization. You decide to inform higher management of his illegal behavior. What is the chance that YOUR future career at the company will be harmed by reporting him?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

12. Your company has a strict policy forbidding the removal of computer equipment from the work premises. However, you have a big project due that can only be completed if you "borrow" a company laptop computer over the weekend. What is the probability that YOU could secretly remove the computer for the weekend and return it to work on Monday without ever being caught?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

13. You are a foreigner living in a war-torn country that is filled with violence and frequent sniper attacks. Although it is dark outside and there are many hostile insurgents in the area, you decide to drive alone and unarmed down a 10 mile stretch of empty highway to spend the weekend in the next town. What is the probability that YOU will be killed while making the trip?

    0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

14. While staying at a high rise hotel a bad fire breaks out several floors below yours. After hearing the fire alarm and smelling smoke, you quickly devise a plan of escape. What is the likelihood that YOU would be unable to figure out a way to escape and would die in the fire?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

15. A severe natural disaster has devastated your town, resulting in widespread panic, looting, and deadly violence. The escape routes leading from the town are blocked with gridlock traffic and street gangs are killing at random and using violent means to steal limited necessities and survive. What is the chance that YOU will be able to outmaneuver the looters and escape the town unharmed?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

16. You enter a competition in an arena in which you are particularly talented. What is the chance that YOU will ultimately win the competition?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

17. You are sightseeing off a tall bridge where many individuals have tried to commit suicide by jumping to their deaths in the water below. Approximately half of all jumpers have not survived the long drop into the bay. Unfortunately, you stumble and are accidentally knocked off of the bridge. What is the likelihood that YOU would die in the fall?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

18. Your biggest rival has challenged you in some way. What is the likelihood that YOU will ultimately defeat your rival at whatever he/she has challenged you with?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

19. A bad automobile accident has just occurred in front of you. In one of the cars, the driver is unconscious and bleeding. You smell gas and notice that smoke is starting to billow out from the car. Afraid that the car may explode at any moment, you work to pull the unconscious driver from the car. What is the chance that YOU will die in the process of saving the driver?

0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%

20. While on vacation on a tropical island you decided to rent a small motor boat to do some sightseeing and fishing out along the island coast. After stopping the boat some distance from the shore you lay down to take a brief nap. Upon awakening you realize that you can no longer see the shore and notice that there is a fierce storm coming. What is the likelihood that YOU will die at sea?

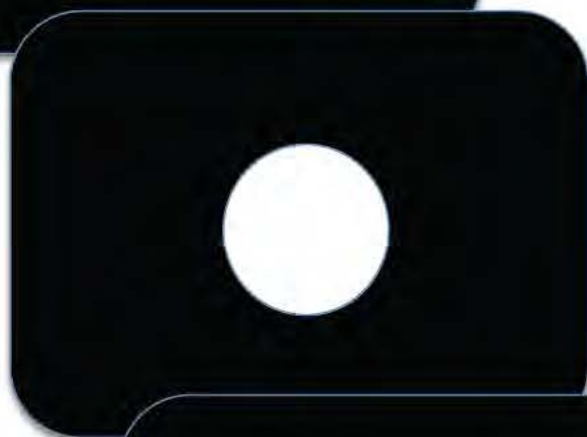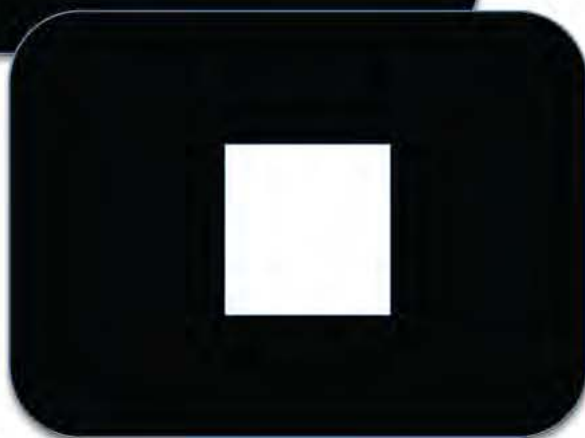0%   10%   20%   30%   40%   50%   60%   70%   80%   90%   100%
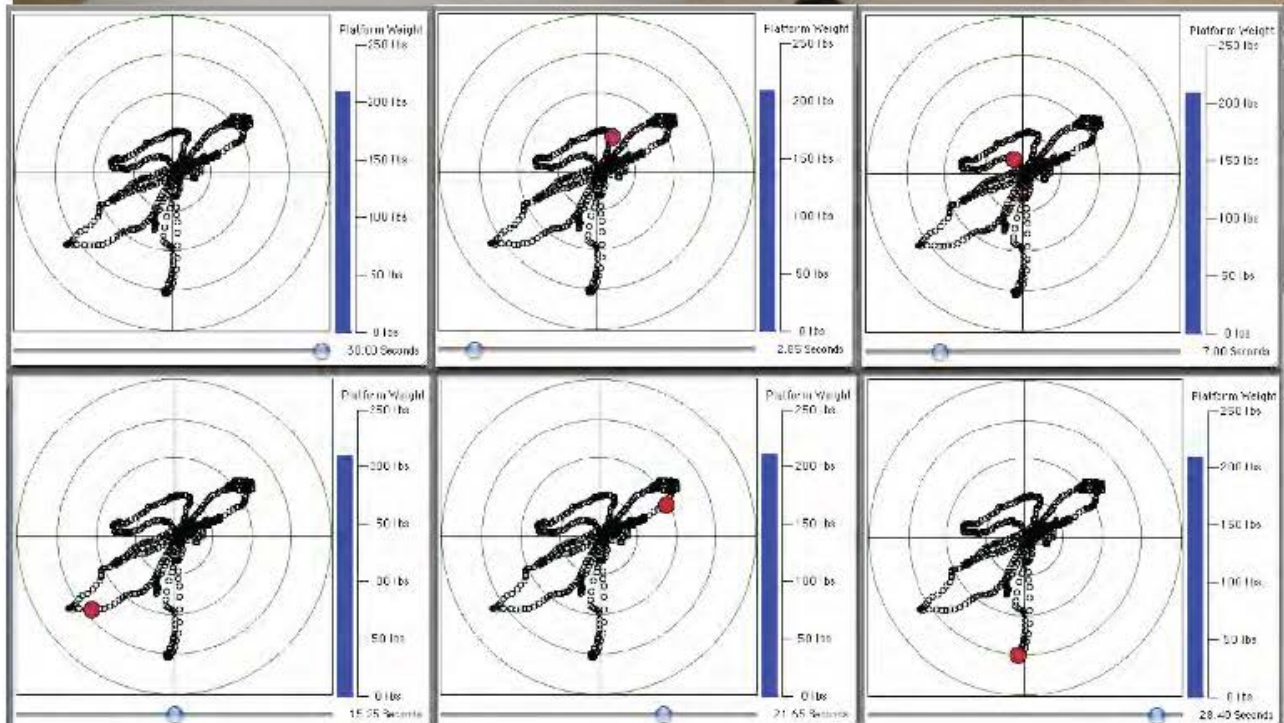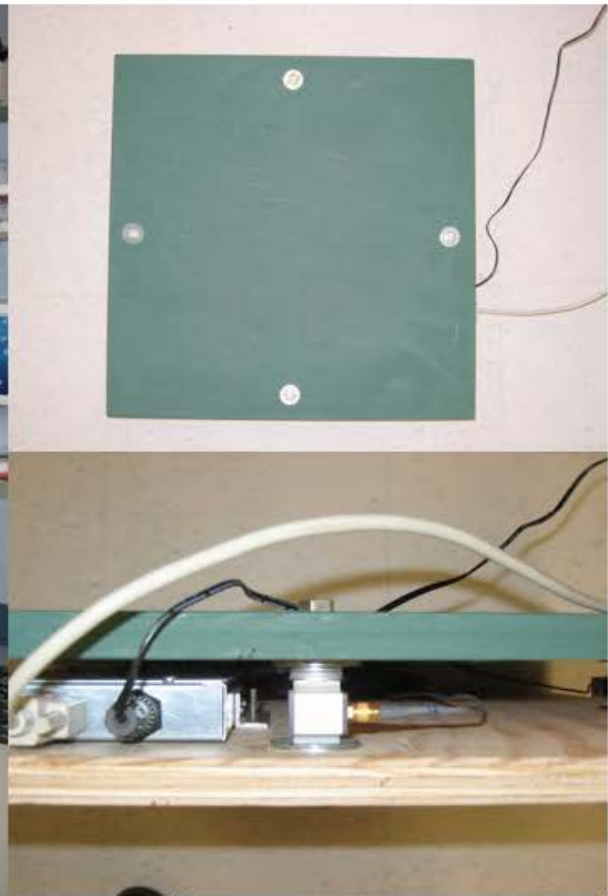
Go/No-Go Task
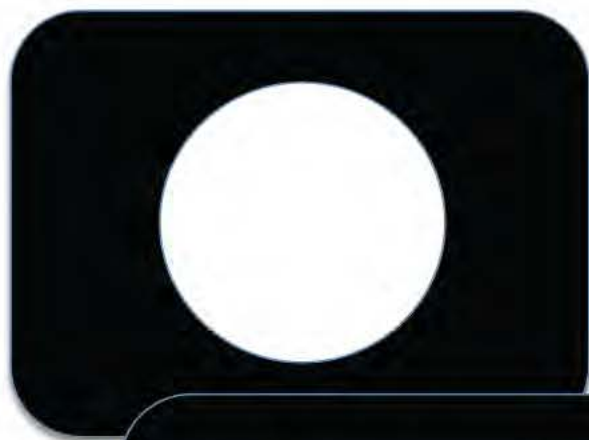
Go
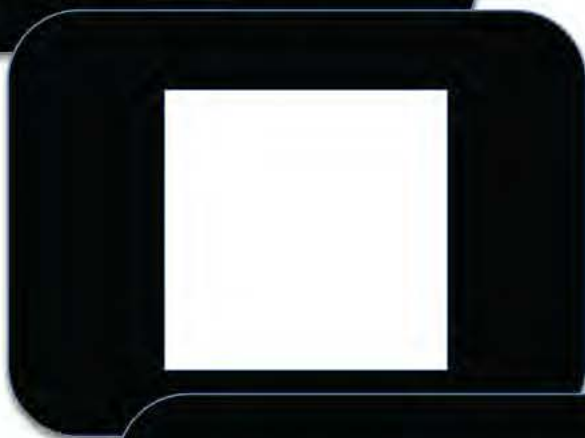
Go

Go

No Go

Body Sway and Stability Test

Day of Scan Information Questionnaire

Subject #: _____ **Date:** _____

DATE OF BIRTH _____/_____/_____
                    day   month   year

AGE .... _____ years
HEIGHT .... _____ ft/inches
WEIGHT .... _____ lbs
SEX …………………………………………. **Male   Female**

RIGHT or LEFT-HANDED? .... **RIGHT   LEFT   BOTH/NEITHER**

How far did you go in school?
<9th; 9th; 10th; 11th; HS Grad; 2yr College; College Grad; Some Grad School; Masters, Doctorate

Do you have any problems with reading? NO   YES _____

What is your primary language (what do you speak at home most of the time)?

English   Spanish   Other _____

CAFFEINE USE
Did you have any caffeine containing products today? If so, how much? _____
On average, how many cups of caffeinated coffee do you drink per day?   _____
On average, how many cups of caffeinated tea do you drink per day?   _____
On average, how many cans of caffeinated soda do you drink per day?   _____
On average, how many caffeinated sports drinks do you drink per day?   _____(brand)
Do you use any other caffeinated products, such as Vivarin?   **YES   NO**
If YES, **WHAT**? _____ How much?_____ How often? _____

NICOTINE USE
Do you smoke cigarettes?   **YES   NO**
    If **YES**, about how many cigarettes do you smoke per day? _____
        How long have you been smoking? _____ **years** _____ **months**
        Have you tried to quit?   **YES   NO**
            If **YES**, how many times? _____
    If **NO**, did you ever smoke cigarettes in the past?   **YES   NO**
        If **YES**, how many cigarettes did you smoke per day? _____
        When did you start smoking? _____ (date)
        When did you quit?   _____ (date)
Do you use smokeless tobacco, such as dip or chew?   **YES   NO**
    If **YES**, about how much do you use per day? _____
    If **NO**, did you ever use smokeless tobacco in the past?   **YES   NO**
        If **YES**, how much did you use per day? _____
        When did you start using?   _____ (year)
        When did you quit?   _____ (year)

Do you use any other nicotine-containing products?   **YES   NO**
        If YES, **WHAT**? _____ How much?_____ How often? _____

OTHER
Do you take diet pills?   **YES   NO**
        If **YES**, what brand? _____ How much?_____ How often? _____
Are you currently taking any medications, vitamins, or supplements?   **YES   NO**
        If **YES**, please list:
        Name: _____   Dosage: _____
        Name: _____   Dosage: _____
        Name: _____   Dosage: _____
        Name: _____   Dosage: _____
How many times per month do you drink (alcohol)?   _____
        On those occasions, what is the average number of drinks you consume? _____
        On those occasions, what is the largest number of drinks you consume? _____
How many times in the past year have you used marijuana?   _____
Have you ever used marijuana at other times in your life?   **YES   NO**
        If **YES**, at what age did you begin smoking marijuana? _____
        On approximately how many occasions have you used marijuana? _____
Do you use any other street drugs currently or in the past year?   **YES   NO**
        If YES, **WHAT**? _____ How much?_____ How often? _____

PHYSICAL INFORMATION
If female, when was the start of your last menstrual period (be as precise as possible)?
        Date of period:_____ or about _____days ago.

CONCUSSION INFORMATION

How many "concussions" have you had in your life? _____
Did you lose consciousness or get "knocked out" each time? _____
How long ago was your most recent concussion? _____ Date it happened: _____
Briefly describe the situation that led to your most recent concussion:
_____
_____

Did you "see stars" during your last concussion? **YES   NO**
Did you lose consciousness during your last concussion? **YES   NO**
    (If "YES", for how long were you unconscious: _____)
Did you notice that your sleep became worse following the concussion? **YES   NO**
After your concussion, what sleep problems became more noticeable to you? (check all that apply)
        _____ I get sleepier during the day
        _____ I get drowsier than I used to when trying to concentrate or work
        _____ I fall asleep when I should not
        _____ It is harder to stay alert during the day
        _____ It is harder to fall asleep at night
        _____ I fall asleep much later than I used to
        _____ I fall asleep much earlier than I used to
        _____ I sleep later in the morning than I used to
        _____ I wake up much earlier in the morning than I used to

_____ When I do sleep, it is fitful or less restful than it used to be
_____ I wake up off and on throughout the night more than I used to
_____ I have more nightmares than I used to

In the months **BEFORE** your concussion occurred:

Before your concussion, at what time did you normally go to bed at night on:
    Week nights (Sun-Thur)?   _____ AM PM (midnight = 12 AM; noon = 12 PM)
    weekends (Fri-Sat)?   _____ AM PM

Before your concussion, what time did you typically awaken on:
    weekdays (Mon-Fri)?   _____ AM PM
    weekends (Sat-Sun)?   _____ AM PM

Before your concussion, how long did it typically take you to fall asleep at night?
    on week nights (Sun-Thur)?   _____ MIN HRS
    on weekends (Fri-Sat)?   _____ MIN HRS

CURRENT SLEEP HABITS

How much sleep did you get last night? _____

Since your concussion, how much do you typically sleep on weeknights (Sun-Thur)? _____

Since your concussion, how much do you typically sleep on weekend nights (Fri-Sat)?_____

Since your concussion, at what time do you normally go to bed at night on:
    week nights (Sun-Thur)?   _____ AM PM (midnight = 12 AM; noon = 12 PM)
    weekends (Fri-Sat)?   _____ AM PM

Since your concussion, what time do you typically awaken on:
    weekdays (Mon-Fri)?   _____ AM PM
    weekends (Sat-Sun)?   _____ AM PM

Since your concussion, how long does it typically take you to fall asleep at night?
    on week nights (Sun-Thur)?   _____ MIN HRS
    on weekends (Fri-Sat)?   _____ MIN HRS

Since your concussion, at what time of day do you feel sleepiest? _____ AM PM
At what time of day do you feel most alert? _____ AM PM

Since your concussion, how many hours do you need to sleep to feel your best? _____

"Since your concussion…"
"If I get less than _____ hours of sleep, I notice an impairment in my ability to function at work."
"If I get more than _____ hours of sleep, I notice an impairment in my ability to function at work."

Is daytime sleepiness currently a problem for you? ....**YES NO**

Are you currently doing shift work, that is, working early morning, evening, or night shifts?...YES   NO

Do you ever have trouble falling asleep? ....YES   NO
If yes, how often?   _____ times per WEEK   MONTH   YEAR   (circle one)
If yes, did this get start or get worse since your concussion? **YES NO**

Do you ever have trouble staying asleep? ....YES   NO
If yes, how often?   _____ times per WEEK   MONTH   YEAR   (circle one)
If yes, did this start or get worse since your concussion? **YES   NO**

Do you take more than two daytime naps per month? .... **YES   NO**
If yes, about how many times per week do you nap? ....   _____
At what time of day do you normally take your nap?   ____:____ AM/PM   to   ____:____AM/PM
Do you consider yourself a light, normal, or heavy sleeper? ....**LIGHT   NORMAL   HEAVY**
Have you been told or do you think that you snore excessively? **YES   NO**
Have you ever been diagnosed or treated for sleep apnea or sleep disordered breathing? **YES   NO**

I yawn often
        Never   **1   2   3   4   5   6   7   8   9   10**   Always yawning

When I see or hear someone else yawn, I will yawn too
        Never   **1   2   3   4   5   6   7   8   9   10**   Every time

RECENT RISK OF DOZING OFF (ESS)

How likely are to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your **usual way of life in recent times**. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

 0 = would never doze
 1 = slight chance of dozing
 2 = moderate chance of dozing
 3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0-3)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Second Day of Scan Information Questionnaire

Subject #: _____ **Date:** _____

CAFFEINE USE

Did you have any caffeine containing products today? If so, how much? _____

On average, how many cups of caffeinated coffee do you drink per day?   _____

On average, how many cups of caffeinated tea do you drink per day?   _____

On average, how many cans of caffeinated soda do you drink per day?   _____

On average, how many caffeinated sports drinks do you drink per day?   _____(brand)

Do you use any other caffeinated products, such as Vivarin?   **YES   NO**

If YES, **WHAT**? _____ How much?_____ How often? _____

NICOTINE USE

Do you smoke cigarettes?   **YES   NO**

    If **YES**, about how many cigarettes do you smoke per day? _____

        How long have you been smoking? _____ **years** _____ **months**

        Have you tried to quit?   **YES   NO**

            If **YES**, how many times? _____

    If **NO**, did you ever smoke cigarettes in the past?   **YES   NO**

        If **YES**, how many cigarettes did you smoke per day? _____

        When did you start smoking? _____ (date)

        When did you quit?   _____ (date)

Do you use smokeless tobacco, such as dip or chew?   **YES   NO**

    If **YES**, about how much do you use per day? _____

    If **NO**, did you ever use smokeless tobacco in the past?   **YES   NO**

        If **YES**, how much did you use per day? _____

        When did you start using?   _____ (year)

        When did you quit?   _____ (year)

Do you use any other nicotine-containing products?   **YES   NO**

    If YES, **WHAT**? _____ How much?_____ How often? _____

OTHER

Do you take diet pills?   **YES   NO**

    If **YES**, what brand? _____ How much?_____ How often?

Are you currently taking any medications, vitamins, or supplements?   **YES   NO**

    If **YES**, please list:

    Name: _____   Dosage: _____

    Name: _____   Dosage: _____

    Name: _____   Dosage: _____

    Name: _____   Dosage: _____

How many times per month do you drink (alcohol)?   _____

    On those occasions, what is the average number of drinks you consume? _____

    On those occasions, what is the largest number of drinks you consume? _____

How many times in the past year have you used marijuana?   _____

Have you ever used marijuana at other times in your life?   **YES   NO**

    If **YES**, at what age did you begin smoking marijuana? _____

    On approximately how many occasions have you used marijuana? _____

Do you use any other street drugs currently or in the past year?   **YES   NO**
    If YES, **WHAT**? _____ How much?_____   How often? _____

PHYSICAL INFORMATION

If female, when was the start of your last menstrual period (be as precise as possible)?
    Date of period:_____ or about _____days ago.

CURRENT SLEEP HABITS

How much sleep did you get last night? _____

In the past two weeks, how much do you typically sleep on weeknights (Sun-Thur)? _____

In the past two weeks, how much do you typically sleep on weekend nights (Fri-Sat)?_____

In the past two weeks, at what time do you normally go to bed at night on:
    week nights (Sun-Thur)?   _____ AM   PM (midnight = 12 AM; noon = 12 PM)
    weekends (Fri-Sat)?   _____ AM   PM

In the past two weeks, what time do you typically awaken on:
    weekdays (Mon-Fri)?   _____ AM   PM
    weekends (Sat-Sun)?   _____ AM   PM

In the past two weeks, how long does it typically take you to fall asleep at night?
    on week nights (Sun-Thur)?   _____ MIN   HRS
    on weekends (Fri-Sat)?   _____ MIN   HRS

In the past two weeks, at what time of day do you feel sleepiest?   _____ AM   PM
At what time of day do you feel most alert?   _____ AM   PM

In the past two weeks, how many hours do you need to sleep to feel your best? _____

"In the past two weeks…"
"If I get less than _____ hours of sleep, I notice an impairment in my ability to function at work."
"If I get more than _____ hours of sleep, I notice an impairment in my ability to function at work."
In the past two weeks:

Is daytime sleepiness currently a problem for you? ....**YES   NO**

Are you currently doing shift work, that is, working early morning, evening, or night shifts?...YES   NO

Do you ever have trouble falling asleep? ....YES   NO
If yes, how often?   _____ times per WEEK   MONTH   YEAR (circle one)

Do you ever have trouble staying asleep? ....YES   NO
If yes, how often?   _____ times per WEEK   MONTH   YEAR (circle one)

Do you take more than two daytime naps per month? .... **YES NO**
If yes, about how many times per week do you nap? .... _____
At what time of day do you normally take your nap?   ____:____ AM/PM to   ____:____AM/PM
Do you consider yourself a light, normal, or heavy sleeper? ....**LIGHT NORMAL HEAVY**
Have you been told or do you think that you snore excessively? **YES NO**
Have you ever been diagnosed or treated for sleep apnea or sleep disordered breathing? **YES NO**

I yawn often
      Never **1 2 3 4 5 6 7 8 9 10** Always yawning

When I see or hear someone else yawn, I will yawn too
      Never **1 2 3 4 5 6 7 8 9 10** Every time

RECENT RISK OF DOZING OFF (ESS)

How likely are to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your **usual way of life in the last two weeks**. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

 0 = would never doze
 1 = slight chance of dozing
 2 = moderate chance of dozing
 3 = high chance of dozing

SITUATION   CHANCE OF DOZING (0-3)

SITUATION				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

MEQ

SUBJECT:_____ DATE: _____/_____/_____

1. Considering only your own "feeling best" rhythm, at what time would you get up if you were entirely free to plan your day?
   _____5:00 - 6:30 AM
   _____6:30 - 7:45 AM
   _____7:45 - 9:45 AM
   _____9:45 - 11:00 AM
   _____11:00 AM - 12:00 PM

2. Considering only your own "feeling best" rhythm, at what time would you go to bed if you were entirely free to plan your evening?
   _____8:00 - 9:00 PM
   _____9:00 - 10:15 PM
   _____10:15 PM - 12:30 AM
   _____12:30 - 1:45 AM
   _____1:45 - 3:00 AM

3. If there is a specific time at which you have to get up in the morning, to what extent are you dependent on being woken up by an alarm clock?
   _____not at all dependent
   _____slightly dependent
   _____fairly dependent
   _____very dependent

4. Assuming adequate environmental conditions, how easy do you find getting up in the mornings?
   _____not at all easy
   _____not very easy
   _____fairly easy
   _____very easy

5. How alert do you feel during the first half hour after having woken in the mornings?
   _____not at all alert
   _____slightly alert
   _____fairly alert
   _____very alert

6. How is your appetite during the first half-hour after having woken in the mornings?
   _____very poor
   _____fairly poor
   _____fairly good
   _____very good

7. During the first half-hour after having woken in the morning, how tired do you feel?
   _____very tired
   _____fairly tired
   _____fairly refreshed
   _____very refreshed

8. When you have no commitments the next day, at what time do you go to bed compared to your usual bedtime?

     _____seldom or never later
     _____less than one hour later
     _____1-2 hours later
     _____more than two hours later

9. You have decided to engage in some physical exercise. A friend suggests that you do this one hour twice a week and the best time for him is between 7:00-8:00 AM. Bearing in mind nothing else but your own "feeling best" rhythm how do you think you would perform?
    _____would be in good form
     _____would be in reasonable for
     _____would find it difficult
     _____would find it very difficult

10. At what time in the evening do you feel tired and as a result in need of sleep?
     _____8:00 - 9:00 PM
     _____9:00 - 10:15 PM
    ____10:15 PM - 12:45 AM
    ____12:45 - 2:00 AM
    ____2:00 - 3:00 AM

11. You wish to be at your peak performance for a test which you know is going to be mentally exhausting and lasting for two hours. You are entirely free to plan your day and considering only your own "feeling best" rhythm which ONE of the four testing times would you choose?
     _____8:00 - 10:00 AM
     _____11:00 AM - 1:00 PM
     _____3:00 - 5:00 PM
     _____7:00 - 9:00 PM

12. If you went to bed at 11:00 PM at what level of tiredness would you be?
     _____not at all tired
     _____a little tired
     _____fairly tired
     _____very tired

13. For some reason you have gone to bed several hours later than usual, but there is no need to get up at any particular time the next morning. Which ONE of the following events are you most likely to experience?
     _____will wake up at usual time and will NOT fall asleep
     _____will wake up at usual time and will doze thereafter
     _____will wake up at usual time but will fall asleep again
     _____will NOT wake up until later than usual

14. One night you have to remain awake between 4:00 - 6:00 AM in order to carry out a night watch. You have no commitments the next day. Which ONE of the following alternatives will suit you best?
     _____would NOT go to bed until watch was over
     _____would take a nap before and sleep after
     _____would take a good sleep before and nap after
     _____would take ALL sleep before watch

15. You have to do two hours of hard physical work. You are entirely free to plan your day and considering only your own "feeling best" rhythm which ONE of the following times would you choose?

   _____8:00 - 10:00 AM
   _____11:00 AM - 1:00 PM
   _____3:00 - 5:00 PM
   _____7:00 - 9:00 PM

16. You have decided to engage in hard physical exercise. A friend suggests that you do this for one hour twice a week and the best time for him is between 10:00 - 11:00 PM. Bearing in mind nothing else but your own "feeling best" rhythm how well do you think you would perform?

   _____would be in good form
   _____would be in reasonable form
   _____would find it difficult
   _____would find it very difficult

17. Suppose that you can choose your own work hours. Assume that you worked a FIVE-hour day (including breaks) and that your job was interesting and paid by results. During which time period would you want that five consecutive hours to END?

   _____12:00 - 4:00 AM
   _____4:00 - 8:00 AM
   _____8:00 - 9:00 AM
   _____9:00 AM - 2:00 PM
   _____2:00 - 5:00 PM
   _____5:00 PM - 12:00 AM

18. At what time of the day do you think that you reach your "feeling best" peak?

   _____12:00 - 5:00 AM
   _____5:00 - 8:00 AM
   _____8:00 - 10:00 AM
   _____10:00 AM - 5:00 PM
   _____5:00 - 10:00 PM
   _____10:00 PM - 12:00 AM

19. One hears about "morning" and "evening" types of people. Which ONE of these types do you consider yourself to be?

   _____definitely a "morning" person
   _____rather more a "morning" than an "evening" type
   _____rather more an "evening" than a "morning" type
   _____definitely an "evening" type

FOSQ

Study ID _____   Date_____

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Please circle one answer for each question. Please try to be as accurate as possible.

0 – I don't do this activity for other reasons
1 – No difficulty
2 – Yes, a little difficulty
3 – Yes, Moderate difficulty
4 – Yes, Extreme difficulty

1. Do you generally have difficulty concentrating on things you do because you are sleepy or tired? **0   1   2   3   4**

2. Do you generally have difficulty remembering things because you are sleepy or tired? **0   1   2   3   4**

3. Do you have difficulty finishing a meal because you become sleepy or tired? **0   1   2   3   4**

4. Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired? **0   1   2   3   4**

5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired? **0   1   2   3   4**

6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired? **0   1   2   3   4**

7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired? **0   1   2   3   4**

8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation? **0   1   2   3   4**

9. Do you have difficulty take care of financial affairs and doing paperwork (for example: writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired? **0   1   2   3   4**

10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired? **0   1   2   3   4**

11. Do you have difficulty maintaining a telephone conversation because you become sleepy or tired? **0   1   2   3   4**

0 – I don't do this activity for other reasons

1 – No difficulty
2 – Yes, a little difficulty
3 – Yes, Moderate difficulty
4 – Yes, Extreme difficulty

	0	1	2	3	4
12. Do you have difficulty visiting with your family or friends in **your** home because you become sleepy or tired?	0	1	2	3	4
13. Do you have difficulty visiting with your family or friends in **their** homes because you become sleepy or tired?	0	1	2	3	4
14. Do you have difficulty doing things for your family or friends because you become sleepy or tired?	0	1	2	3	4
15. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?		1	2	3	4
16. Do you have difficulty exercising or participating in a sporting activity because you are too sleepy or tired?	0	1	2	3	4
17. Do you have difficulty watching a movie or videotape because you become sleepy or tired?	0	1	2	3	4
18. Do you have difficulty enjoying the theater or a lecture because you become sleepy or tired?	0	1	2	3	4
19. Do you have difficulty enjoying a concert because you become sleepy or tired?	0	1	2	3	4
20. Do you have difficulty watching television because you are sleepy or tired?	0	1	2	3	4
21. Do you have difficulty participating in religious services, meetings or a group club because you are sleepy or tired?	0	1	2	3	4
22. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	0	1	2	3	4
23. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	0	1	2	3	4
24. Do you have difficulty being as active as you want to be in the afternoon because you are sleepy or tired?	0	1	2	3	4
25. Do you have difficulty keeping a pace with others your own age because you are sleepy or tired?	0	1	2	3	4
26. How would you rate yourself in your general level of activity?		1	2	3	4

1= Very low; 2= Low;
3= Medium; 4= High

	0	1	2	3	4
27. Has your intimate or sexual relationship been affected because you are sleepy or tired?	0	1	2	3	4
28. Has your desire for intimacy or sex been affected because you are sleepy or tired?	0	1	2	3	4
29. Has your ability to become sexually aroused been affected because you are sleepy or tired?	0	1	2	3	4
30. Has your ability to have an orgasm been affected because you are sleepy or tired?	0	1	2	3	4

1. Please mark the bubble which best describes your feelings **RIGHT NOW**.

I feel like gambling

not at all ○○○○○○○○○○○○○○○○○○○○ very much

I am driving and the light turns yellow. I feel like

stopping ○○○○○○○○○○○○○○○○○○○○ accelerating

The lights suddenly go out in an unfamiliar stairwell

I don't move ○○○○○○○○○○○○○○○○○○○○ I proceed immediately

I feel like

avoiding everyone ○○○○○○○○○○○○○○○○○○○○ taking on the world

I feel like diving from a diving board, which is

very high ○○○○○○○○○○○○○○○○○○○○ very low

I like

routine ○○○○○○○○○○○○○○○○○○○○ adventure

I seek

the thrill of danger ○○○○○○○○○○○○○○○○○○○○ tranquillity

I am in a hurry

I take a dangerous shortcut ○○○○○○○○○○○○○○○○○○○○ I take a safe detour

I am open to

negotiation ○○○○○○○○○○○○○○○○○○○○ confrontation

I prefer to

direct ○○○○○○○○○○○○○○○○○○○○ be supervised

I give priority to

reason ○○○○○○○○○○○○○○○○○○○○ action

I like to listen to music

at a loud volume ○○○○○○○○○○○○○○○○○○○○ very softly

I am sure of myself

not at all ○○○○○○○○○○○○○○○○○○○○ completely

I prefer discussions, which are

animated ○○○○○○○○○○○○○○○○○○○○ calm

A hostile situation

weakens me ○○○○○○○○○○○○○○○○○○○○ reinforces me

A menacing dog approaches

I confront it ○○○○○○○○○○○○○○○○○○○○ I run away

Faced with a potentially dangerous event

I take my time ○○○○○○○○○○○○○○○○○○○○○○○○ I instantly react

Seeing a person who is drowning, I first

dive in ○○○○○○○○○○○○○○○○○○○○○○○○ call for help

I prefer work that is

well planned ○○○○○○○○○○○○○○○○○○○○○○○○ not planned

I am right

all the time ○○○○○○○○○○○○○○○○○○○○○○○○ never

I emphasize

precision ○○○○○○○○○○○○○○○○○○○○○○○○ speed

I like to drive

very fast ○○○○○○○○○○○○○○○○○○○○○○○○ very slow

I like to listen to music with a tempo that is

very slow ○○○○○○○○○○○○○○○○○○○○○○○○ very fast

I like to take risks

not at all ○○○○○○○○○○○○○○○○○○○○○○○○ a lot

THANK YOU FOR COMPLETING THIS SURVEY!

Please provide any additional comments below or on the back of the survey, if needed.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____   DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns   _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).   TOTAL: _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all   _____

Somewhat difficult   _____

Very difficult   _____

Extremely difficult   _____

Session (1 or 2) _____ID#_____Date_____Time_____

AM

PM

PITTSBURGH SLEEP QUALITY INDEX

INSTRUCTIONS:
The following questions relate to your usual sleep habits during the past month <u>only</u>. Your answers should indicate the most accurate reply for the <u>majority</u> of days and nights in the past month.
Please answer all questions.

1.   During the past month, what time have you usually gone to bed at night?

BED TIME _____

2.   During the past month, how long (in minutes) has it usually taken you to fall asleep each night?

NUMBER OF MINUTES _____

3.   During the past month, what time have you usually gotten up in the morning?

GETTING UP TIME _____

4.   During the past month, how many hours of <u>actual</u> <u>sleep</u> did you get at night? (This may be different than the number of hours you spent in bed.)

HOURS OF SLEEP PER NIGHT _____

For each of the remaining questions, check the one best response. Please answer <u>all</u> questions.

5.   During the past month, how often have you had trouble sleeping because you . . .

a)   Cannot get to sleep within 30 minutes

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

b)   Wake up in the middle of the night or early morning

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

c)   Have to get up to use the bathroom

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

d) Cannot breathe comfortably

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

e) Cough or snore loudly

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

f) Feel too cold

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

g) Feel too hot

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

h) Had bad dreams

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

i) Have pain

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

j) Other reason(s), please describe_____

_____

How often during the past month have you had trouble sleeping because of this?

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

6. During the past month, how would you rate your sleep quality overall?

Very good   _____

Fairly good _____

Fairly bad   _____

Very bad   _____

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")?

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

No problem at all   _____

Only a very slight problem   _____

Somewhat of a problem   _____

A very big problem   _____

10. Do you have a bed partner or room mate?

No bed partner or room mate   _____

Partner/room mate in other room   _____

Partner in same room, but not same bed   _____

Partner in same bed   _____

If you have a room mate or bed partner, ask him/her how often in the past month you have had . . .

a) Loud snoring

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

b) Long pauses between breaths while asleep

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

c) Legs twitching or jerking while you sleep

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

d)   Episodes of disorientation or confusion during sleep

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

e)   Other restlessness while you sleep; please describe_____

_____

Not during the   Less than   Once or twice   Three or more
past month_____   once a week_____   a week_____   times a week_____

Rivermead Post Concussion Symptoms Questionnaire

Modified (Rpq-3 And Rpq-13)[42] Printed With Permission: Modified Scoring System From Eyres 2005 [28]

Name:	Date:

After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer.

0 = not experienced at all
1 = no more of a problem
2 = a mild problem
3 = a moderate problem
4 = a severe problem

Compared with **before** the accident, do you **now** (i.e., over the last 24 hours) suffer from:

	not experienced	no more of a problem	mild problem	moderate problem	severe problem
Headaches	0	1	2	3	4
Feelings of dizziness	0	1	2	3	4
Nausea and/or vomiting	0	1	2	3	4
Noise sensitivity (easily upset by loud noise)	0	1	2	3	4
Sleep disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being irritable, easily angered	0	1	2	3	4
Feeling depressed or tearful	0	1	2	3	4
Feeling frustrated or impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor concentration	0	1	2	3	4
Taking longer to think	0	1	2	3	4
Blurred vision	0	1	2	3	4
Light sensitivity (easily upset by bright light)	0	1	2	3	4
Double vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Please specify, and rate as above.

1.	0	1	2	3	4
2.	0	1	2	3	4

Administration only:

RPQ-3 *(total for first three items)*	
RPQ-13 *(total for next 13 items)*	

Administration only

Individual item scores reflect the presence and severity of post concussive symptoms. Post concussive symptoms, as measured by the RPQ, may arise for different reasons subsequent to (although not necessarily directly because of) a traumatic brain injury. The symptoms overlap with broader conditions, such as pain, fatigue and mental health conditions such as depression[72].

The questionnaire can be repeated to monitor a patient's progress over time. There may be changes in the severity of symptoms, or the range of symptoms. Typical recovery is reflected in a reduction of symptoms and their severity within three months.

Scoring

The scoring system has been modified from Eyres, 2005[24].

The items are scored in two groups. The first group (RPQ-3) consists of the first three items (headaches, feelings of dizziness and nausea) and the second group (RPQ-13) comprises the next 13 items. The total score for RPQ-3 items is potentially 0–12 and is associated with early symptom clusters of post concussive symptoms. If there is a higher score on the RPQ-3, earlier reassessment and closer monitoring is recommended.

The RPQ-13 score is potentially 0–52, where higher scores reflect greater severity of post concussive symptoms. The RPQ-13 items are associated with a later cluster of symptoms, although the RPQ-3 symptoms of headaches, dizziness and nausea may also be present. The later cluster of symptoms is associated with having a greater impact on participation, psychosocial functioning and lifestyle. Symptoms are likely to resolve within three months. A gradual resumption of usual activities is recommended during this period, appropriate to symptoms. If the symptoms do not resolve within three months, consideration of referral for specialist assessment or treatment services is recommended.

References:

Eyres, S., Carey, A., Gilworth, G., Neumann, V., Tennant, A. (2005). Construct validity and reliability of the Rivermead Post Concussion Symptoms Questionnaire. *Clinical Rehabilitation*, 19, 878-887.

King, N. S., Crawford, S., Wenden, F.J., Moss, N.E.G. Wade, D.T. (1995). The Rivermead Post Concussion Symptoms Questionnaire: a measure of symptoms commonly experienced after head injury and its reliability *Journal of Neurology*, 242, 587-592.

Potter, S., Leigh, E., Wade, D., Fleminger, S. (2006). The Rivermead Post Concussion Symptoms Questionnaire *Journal of Neurology*, October 1-12.

BDI

SUBJECT ID#:_____   DATE: _____/_____/_____

INSTRUCTIONS: On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling in the **PAST WEEK, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0   I do not feel sad.
    1   I feel sad.
    2   I am sad all the time and I can't snap out of it.
    3   I am so sad or unhappy that I can't stand it.

2. 0   I am not particularly discouraged about the future.
    1   I feel discouraged about the future.
    2   I feel I have nothing to look forward to.
    3   I feel that the future is hopeless and that things cannot improve.

3. 0   I do not feel like a failure.
    1   I feel I have failed more than the average person.
    2   As I look back on my life, all I can see is a lot of failures.
    3   I feel I am a complete failure as a person.

4. 0   I get as much satisfaction out of things as I used to.
    1   I don't enjoy things the way I used to.
    2   I don't get real satisfaction out of anything anymore.
    3   I am dissatisfied or bored with everything.

5. 0   I don't feel particularly guilty.
    1   I feel guilty a good part of the time.
    2   I feel quite guilty most of the time.
    3   I feel guilty all of the time.

6. 0   I don't feel I am being punished.
    1   I feel I may be punished.
    2   I expect to be punished.
    3   I feel I am being punished.

7. 0   I don't feel disappointed in myself.
    1   I am disappointed in myself.
    2   I am disgusted with myself.
    3   I hate myself.

8. 0   I don't feel I am any worse than anybody else.
    1   I am critical of myself for my weaknesses or mistakes.
    2   I blame myself all the time for my faults.
    3   I blame myself for everything bad that happens.

9. 0   I don't have any thoughts of killing myself.
    1   I have thoughts of killing myself, but I would not carry them out.
    2   I would like to kill myself.
    3   I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as ever.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I can't make any decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.

16. 0 I can sleep as well as usual.
    1 I don't sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.
      I am purposely trying to lose weight by eating less   YES ____ NO ____

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    2 I am very worried about physical problems and it's hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21.   0   I have not noticed any recent change in my interest in sex.
        1   I am less interested in sex than I used to be.
        2   I am much less interested in sex now.
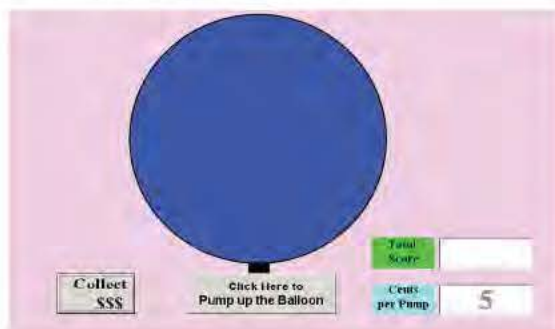   3   I have lost interest in sex completely.

# Balloon Analog Risk Task

Inflate Balloon by Pressing Key
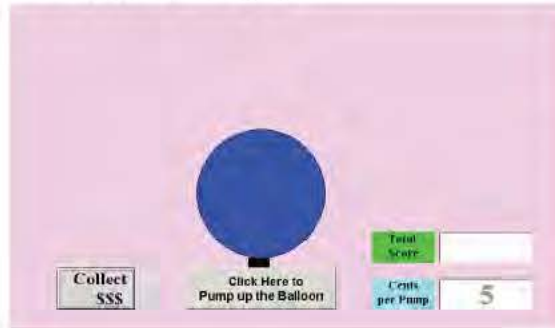
- The BART presents participants with 30 virtual balloons.
- Each balloon can be inflated one increment for each key press.

Balloon Grows in Size and $$$ Value

- With each key press the size of the balloon increases.
- Each increment also increases the potential value of the balloon by 5 cents.
- The balloon can be "cashed in" at any time and the total accumulated value retained.

If Balloon Explodes, All $$$ is Lost
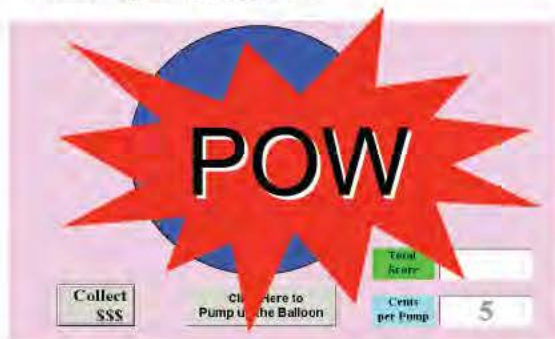
- Each balloon can explode at any time.
- If a balloon explodes, all of the potential money accumulated *for that balloon* will be lost.

Goal: Earn as Much Money as Possible
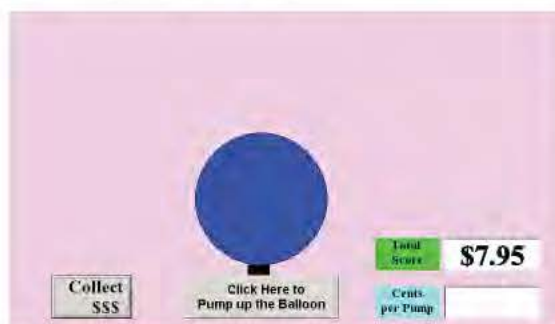
- The goal is to maximize winnings.
- Only 30 balloons are presented

Name: _____ Date: _____

DIRECTIONS: A number of statements which people have used to describe themselves
are given below. Read each statement and then circle the appropriate number
to the right of the statement to indicate how you _feel_ right now, THAT IS, at
this moment.

There are no right or wrong answers.
Do not spend too much time on any one
statement but give the answer which
seems to describe your present
feelings best.

	Not at all	Somewhat	Moderately so	Very much so
1. I feel calm.	1	2	3	4
2. I feel secure.	1	2	3	4
3. I am tense	1	2	3	4
4. I feel regretful	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel rested.	1	2	3	4
9. I feel anxious	1	2	3	4
10. I feel comfortable	1	2	3	4
11. I feel self-confident.	1	2	3	4
12. I feel nervous	1	2	3	4
13. I am jittery	1	2	3	4
14. I feel "high strung"	1	2	3	4
15. I am relaxed	1	2	3	4
16. I feel content	1	2	3	4
17. I am worried	1	2	3	4
18 I feel over-excited and "rattled".	1	2	3	4
19. I feel joyful.	1	2	3	4
20. I feel pleasant.	1	2	3	4

STAI Form T

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you _generally_ feel.

There are no right or wrong answers.
Do not spend too much time on any
one statement but give the answer
which seems to describe how you
generally feel.

		Almost never	Sometimes	Often	Almost always
21.	I feel pleasant.	1	2	3	4
22.	I tire quickly	1	2	3	4
23.	I feel like crying	1	2	3	4
24.	I wish I could be as happy as others seem to be.	1	2	3	4
25.	I am losing out on things because I can't make up my mind soon enough	1	2	3	4
26.	I feel rested.	1	2	3	4
27.	I am "calm, cool, and collected"	1	2	3	4
28.	I feel that difficulties are piling up so that I cannot overcome them	1	2	3	4
29.	I worry too much over something that really doesn't matter	1	2	3	4
30.	I am happy	1	2	3	4
31.	I am inclined to take things hard.	1	2	3	4
32.	I lack self-confidence	1	2	3	4
33.	I feel secure.	1	2	3	4
34.	I try to avoid facing a crises or difficulty	1	2	3	4
35.	I feel blue.	1	2	3	4
36.	I am content	1	2	3	4
37.	Some unimportant thought runs through my mind and bothers me	1	2	3	4
38.	I take disappointments so keenly that I can't put them out of my mind.	1	2	3	4
39.	I am a steady person	1	2	3	4
40.	I get in a state of tension or turmoil as I think over my recent concerns and interests.	1	2	3	4

Tower of London Task

Your Tower
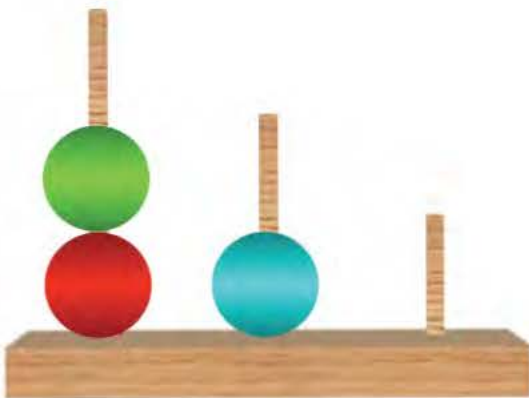
Goal
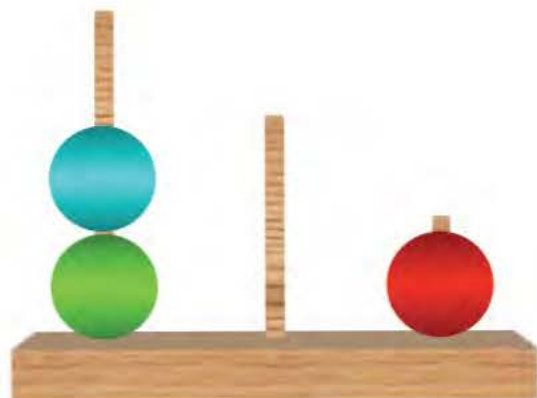
Daily Sleep Diary

Use this sleep diary **every day** to help you track the quantity and quality of your sleep. Reflecting on the previous day, please fill out this diary during your exposure to the lightbox. If you have any questions or concerns, please call **(617)-855-2239.**

Date: _____ **Light box start time:** _____

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____. ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
☐ refreshed
☐ somewhat refreshed
☐ fatigued

I consumed caffeine yesterday:
☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy 1 2 3 4 5 6 7 Very alert

Yesterday my mood was:
Very poor 1 2 3 4 5 6 7 Very good

Yesterday I had problems with headache pain:
Not at all 1 2 3 4 5 6 7 Very severe

Yesterday I ate more than I intended to:
Disagree 1 2 3 4 5 6 7 Agree

Date: _____ **Light box start time:** _____

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____. ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
☐ refreshed
☐ somewhat refreshed
☐ fatigued

I consumed caffeine yesterday
☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy 1 2 3 4 5 6 7 Very alert

Yesterday my mood was:
Very poor 1 2 3 4 5 6 7 Very good

Yesterday I had problems with headache pain:
Not at all 1 2 3 4 5 6 7 Very severe

Yesterday I ate more than I intended to:
Disagree 1 2 3 4 5 6 7 Agree

Date: _____ **Light box start time:** _____

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____. ☐ N/A

Number of caffeinated beverages: _____

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☐ refreshed
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Not at all 1 2 3 4 5 6 7 Very severe

Yesterday I ate more than I intended to:
Disagree 1 2 3 4 5 6 7 Agree

Date: _____ **Light box start time:** _____

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____. ☐ N/A

Number of caffeinated beverages: _____

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☐ refreshed
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Yesterday I had problems with headache pain:
Not at all 1 2 3 4 5 6 7 Very severe

Yesterday I ate more than I intended to:
Disagree 1 2 3 4 5 6 7 Agree

Date: **Light box start time:**

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____ ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
- ☐ refreshed
- ☐ somewhat refreshed
- ☐ fatigued

I consumed caffeine yesterday
- ☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy   1   2   3   4   5   6   7   Very alert

Yesterday my mood was:
Very poor   1   2   3   4   5   6   7   Very good

Yesterday I had problems with headache pain:
Not at all   1   2   3   4   5   6   7   Very severe

Yesterday I ate more than I intended to:
Disagree   1   2   3   4   5   6   7   Agree

Date: **Light box start time:**

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____ ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
- ☐ refreshed
- ☐ somewhat refreshed
- ☐ fatigued

I consumed caffeine yesterday
- ☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy   1   2   3   4   5   6   7   Very alert

Yesterday my mood was:
Very poor   1   2   3   4   5   6   7   Very good

Yesterday I had problems with headache pain:
Not at all   1   2   3   4   5   6   7   Very severe

Yesterday I ate more than I intended to:
Disagree   1   2   3   4   5   6   7   Agree

Date: **Light box start time:**

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____ ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
- ☐ refreshed
- ☐ somewhat refreshed
- ☐ fatigued

I consumed caffeine yesterday
- ☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy   1   2   3   4   5   6   7   Very alert

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Not at all   1   2   3   4   5   6   7   Very severe

Yesterday I ate more than I intended to:
Disagree   1   2   3   4   5   6   7   Agree

Date: **Light box start time:**

Bed time last night _____:_____ ☐ AM ☐ PM

Wake time this morning _____:_____ ☐ AM ☐ PM

It took me _____ (hr) _____ (min) to fall asleep

I woke up _____ times during the night

I took a nap from _____:_____ to _____:_____ ☐ N/A

Number of caffeinated beverages: _____

I woke up this morning feeling
- ☐ refreshed
- ☐ somewhat refreshed
- ☐ fatigued

I consumed caffeine yesterday
- ☐ morning ☐ afternoon ☐ evening

Most of the day yesterday, I felt:
Very sleepy   1   2   3   4   5   6   7   Very alert

Yesterday my mood was:
Very poor   1   2   3   4   5   6   7   Very good

Yesterday I had problems with headache pain:
Not at all   1   2   3   4   5   6   7   Very severe

Yesterday I ate more than I intended to:
Disagree   1   2   3   4   5   6   7   Agree